Center for Better Learning

Better Vision. Brighter Future.

CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully and return it to our office at the time of your child's scheduled vision therapy evaluation appointment.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Gender: ☐Male ☐Female

_____ _____, _____ _____

Street Address City State Zip Code

RESPONSIBLE PERSON(S) INFORMATION

Mother

Name: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Address: ☐ Same Address as Patient

_____ _____, _____ _____

Street Address City State Zip Code

Father

Name: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Address: ☐ Same Address as Patient

_____ _____, _____ _____

Street Address City State Zip Code

PRESENT SITUATION

Were you referred to our office? ☐Yes ☐No

If yes, by whom? _____

Chief Complaint/Reason for the Visit: _____

At which age did you notice the problem? _____

Has the problem become: ☐Better ☐Worse ☐Stayed the Same

Has there been any previous treatment?: ☐Yes ☐No

If yes, please describe:_____

SCHOOL HISTORY

Is your child homeschooled? ☐Yes ☐No

Name of School: _____

Grade: _____

Contact Person: _____

Has your child repeated a grade? ☐Yes ☐No If yes, which grade?: _____
Does your child like school?: ☐Yes ☐No
Does your child like his/her teacher?: ☐Yes ☐No
Is your child's school work: ☐Above Average ☐Average ☐Below Average
Which classes are at or above grade level?:
☐Language Arts ☐Math ☐Music ☐PE ☐Science ☐Social Studies ☐None
Which classes are below grade level?
☐Language Arts ☐Math ☐Music ☐PE ☐Science ☐Social Studies ☐None
Does your child like to read?: ☐Yes ☐No
Does your child prefer to be read to rather than reading on his/her own?: ☐Yes ☐No
Do you feel your child is working up to his/her full potential?: ☐Yes ☐No
Does your child attend any special classes?: ☐Yes ☐No
If yes, please describe:_____
Does your child have an IEP? ☐Yes ☐No
If yes, what accommodations are recommended?:
_____
Has your child been diagnosed with: ☐Dyslexia ☐ADD/ADHD ☐Behavioral Issues

ADDITIONAL TESTING HISTORY

Educational: ☐Yes ☐No If yes, what were the results?: _____
Hearing: ☐Yes ☐No If yes, what were the results?:_____
Neurological: ☐Yes ☐No If yes, what were the results?: _____
Psychological: ☐Yes ☐No If yes, what were the results?: _____
Speech: ☐Yes ☐No If yes, what were the results?: _____
OT/PT: ☐Yes ☐No If yes, what were the results?: _____

MEDICAL HISTORY

Primary Care Doctor: _____

_____ _____, _____ _____
Street Address City State Zip Code
Last Visit Date: _____
Reason for Visit: _____

MEDICAL HISTORY (continued)

Is your child taking any medications? ☐Yes ☐No
If yes, which medications and what dosage?: _____
_____

DEVELOPMENTAL HISTORY

Was your child adopted? ☐Yes ☐No

Was your child: ☐Full Term ☐Premature (under 37 weeks)

Birth Weight: _____ lbs, _____ oz

Were there complications at birth?

☐Toxemia ☐Pre-eclampsia ☐Trauma ☐Alcohol Use ☐Drug Use ☐Severe Illness ☐C-section

If yes to any, please explain: _____

Did your child crawl?: ☐Yes ☐No

If yes, at what age?: _____ For how long?: _____ (days/months/years)

Did your child walk: ☐Early (before 11 months) ☐On Time ☐Late (after 14 months)

Did your child move any other way other than crawl or walk?: ☐Yes ☐No

If yes, please describe: _____

Are your child's gross motor skills: ☐Normal ☐Below Normal

Are your child's fine motor skills: ☐Normal ☐Below Normal

Which hand is your child's dominant hand?: ☐Right ☐Left

At what rate did your child's speech develop? ☐Normal (before 18 months)
☐Delayed (after 18 months)

HEAD INJURY HISTORY

Has your child had any kind of head injury?: ☐Yes ☐No Was he/she hospitalized? ☐Yes ☐No

If yes to head injury, please describe (when, how did it happen, etc.): _____

_____

VISUAL HISTORY

Date of last eye examination: _____ Doctor's Name: _____

Prescribed: ☐Glasses ☐Contacts ☐Optical Devices

Prescribed for: ☐Full-time wear ☐Distance wear only ☐Near wear only

Have the following vision problems been diagnosed?:

Amblyopia (lazy eye): ☐Yes ☐No

If yes, was there any treatment for the Amblyopia?: ☐Yes ☐No

If yes, describe treatment:_____

Strabismus (eye turn): ☐Yes ☐No

If yes, at what age was the eye turn first noticed? _____

Did the eye turn start: ☐Suddenly ☐Gradually Which eye turns?: ☐Left ☐Right ☐Both

Which direction does the eye turn? (check all that apply): ☐In ☐Out ☐Up ☐Down

When does the eye turn? (check all that apply):

☐Always ☐Rarely ☐Beginning of the Day ☐End of the Day ☐When Tired

Has your child had any treatment for the strabismus? ☐Yes ☐No

If yes, describe treatment:_____

ACTIVITIES

(Check the sports or athletic activities your child actively participates in)

☐ Archery	☐ Baseball	☐ Basketball	☐ Cheerleading
☐ Equestrian	☐ Football	☐ Golf	☐ Gymnastics
☐ Ice Hockey	☐ Lacrosse	☐ Martial Arts	☐ Skating
☐ Skiing	☐ Soccer	☐ Softball	☐ Swimming
☐ Tennis	☐ Track and Field	☐ Volleyball	☐ Wrestling

Please list any hobbies or special interests:

_____

Which adjectives best describe your child's personality?

☐ Adaptable	☐ Calm	☐ Careful	☐ Compassionate
☐ Competitive	☐ Courageous	☐ Courteous	☐ Decisive
☐ Dedicated	☐ Driven	☐ Enthusiastic	☐ Helpful
☐ Honest	☐ Industrious	☐ Loyal	☐ Open-minded
☐ Patient	☐ Perfectionist	☐ Responsible	☐ Self-reliant
☐ Self-starter	☐ Stable		

Thank you for taking the time to fill this information out prior to your visit. We look forward to meeting with you.

For in-office use only:

Information reviewed by staff member: _____ Date: _____

VISUAL SYMPTOMS

College of Optometrists in Vision Development (COVD) Symptom List	Never	Seldom	Occasionally	Frequently	Always
Blurred close vision					
Double vision					
Headaches with near work					
Words run together while reading					
Burning, itchy, watery eyes					
Falls asleep while reading					
Sees worse at the end of the day					
Skips/repeats lines while reading					
Dizzy/nauseated by near work					
Head tilt/one eye closed to read					
Difficulty copying from the board					
Avoids near work/reading					
Omits small words when reading					
Writes uphill/downhill					
Misaligns digits/columns of numbers					
Poor reading comprehension					
Poor/inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing work on time					
Says “I can’t” before trying					
Avoids sports/games					
Poor hand/eye coordination					
Poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Poor time use/management					
Does not make change well					
Loses things/belongings					
Car or motion sickness					
Forgetfulness/poor memory					