

Dr. Initials/Date: \_\_\_\_\_ / \_\_\_\_\_

## INITIAL VISION QUESTIONNAIRE FOR SCHOOL-AGE

Appointment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_  
Name your child prefers to go by: \_\_\_\_\_

### GENERAL INFORMATION

Were you referred to our office? Yes  No

By whom? \_\_\_\_\_ His/Her profession: \_\_\_\_\_

Referral address: \_\_\_\_\_ Referral Phone#: \_\_\_\_\_

May we update the referral source? Yes  No

Name and address of school: \_\_\_\_\_

Grade: \_\_\_\_ Teacher: \_\_\_\_\_

Child's dominant hand (circle): right / left / undetermined?

Please list the names and birth dates of your family:

Parent/Caretaker \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Caretaker Occupation? \_\_\_\_\_ Employer \_\_\_\_\_

Parent/Caretaker \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Caretaker Occupation? \_\_\_\_\_ Employer \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

### PRESENT SITUATION

Why does your child need a visual evaluation? \_\_\_\_\_

Has the school/another professional expressed concern regarding your child's vision? Yes  No

If yes, what concern? \_\_\_\_\_

List any other complaints/concerns your child makes concerning his/her vision: \_\_\_\_\_

### VISUAL HISTORY

Has your child's vision been previously evaluated? Yes  No

If so, Doctor's Name: \_\_\_\_\_ Date of last evaluation: \_\_\_\_\_

Reason for examination: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Does your child wear glasses, contact lenses, and/or use a special optical device? Yes  No

If yes, what? \_\_\_\_\_

Are they used? Yes  No  If yes, when? \_\_\_\_\_

If not used, why not? \_\_\_\_\_

***\*For Your Information: We refer out for contact lens fitting, dispensing and follow-up.***

Has your child had eye surgery? Yes  No

By Whom: \_\_\_\_\_

For what: \_\_\_\_\_

Members of the family who have had visual conditions:

Name & Relationship

Age

Visual Situation

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **MEDICAL HISTORY**

Pediatrician's Name: \_\_\_\_\_

May we update your pediatrician? Yes  No

Is your child generally healthy? Yes  No

If no, explain: \_\_\_\_\_

Are there any chronic problems? Yes  No

If yes, please list: \_\_\_\_\_

List illnesses, bad falls, high fevers, etc.:

Age                      Severe                      Mild                      Complications

\_\_\_\_\_

\_\_\_\_\_

Does your child use a mobility aid? Yes  No

If yes, what aid? (Circle) Wheelchair Walker Other: \_\_\_\_\_

Has your child been diagnosed on the autism spectrum? Yes  No

Has your child had an acquired brain injury and/or concussion? Yes  No

If yes, please explain: \_\_\_\_\_

Has a neurological evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results: \_\_\_\_\_

Has a psychological evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results: \_\_\_\_\_

Has an occupational / speech / physical therapy evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results: \_\_\_\_\_

\_\_\_\_\_

### **NUTRITIONAL INFORMATION**

Current Diet: Excellent  Good  Fair  Poor

Explain: \_\_\_\_\_

### **DEVELOPMENTAL HISTORY**

Full-term pregnancy? Yes  No

Did the mother experience any health problems during the pregnancy? Yes  No

If yes, explain: \_\_\_\_\_

Normal birth? Yes  No                       Were forceps used? Yes  No

Any complications before, during, or immediately following delivery? Yes  No

If yes, explain: \_\_\_\_\_

Was there ever a reason for concern over your child's general growth or development? Yes  No

If yes, why? \_\_\_\_\_

Did your child crawl? Yes  No  At what age? \_\_\_\_\_

At what age did your child walk? \_\_\_\_\_

Did your child frequently walk on his/her toes? Yes  No

Is your child's speech clear to others? Yes  No

### TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does your child watch TV? Yes  No  How often? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

Does your child spend time using computer/video games? Yes  No

If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

Does your child spend time using small screen devices (ie. smart phones, tablets, handheld video games) Yes  No  If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_

What other activities occupy your child's leisure time? \_\_\_\_\_

Are there any activities your child would like to participate in, but doesn't? \_\_\_\_\_

Please explain: \_\_\_\_\_

### SCHOOL

Age at time of entrance to: Pre-school \_\_\_\_\_ Kindergarten \_\_\_\_\_ First Grade \_\_\_\_\_

Does your child like school? Yes  No

Describe any school difficulties: \_\_\_\_\_

Has a grade been repeated? Yes  No

If yes, which and why? \_\_\_\_\_

Does your child appear frustrated when doing school/homework? Yes  No

Has your child had special tutoring, therapy, and/or remedial assistance? Yes  No

If yes, when? \_\_\_\_\_

From whom and how long? \_\_\_\_\_

Results: \_\_\_\_\_

Does your child like to read? Yes  No

Voluntarily? Yes  No  Does your child read for pleasure? Yes  No

What? \_\_\_\_\_

What is your child's attitude toward reading, school, his/her teachers, other peers? \_\_\_\_\_

Which school subject are:

Above average: \_\_\_\_\_

Average: \_\_\_\_\_

Below average: \_\_\_\_\_

Does your child need to spend a lot of time/effort to maintain this level of performance? Yes  No

How much time on average does your child spend each day on homework assignments? \_\_\_\_\_

To what extent do you assist your child with homework? \_\_\_\_\_

Do you feel your child is achieving up to potential? Yes  No

Does the teacher feel your child is achieving up to potential? Yes  No

**GENERAL BEHAVIOR**

Are there any behavior concerns at school or at home? Yes  No

If yes, please explain: \_\_\_\_\_

**FAMILY AND HOME**

Please indicate which adult(s) your child lives with: \_\_\_\_\_

Does your child spend time with any other person, not in the home? Yes  No

Please explain: \_\_\_\_\_

Has your child ever been through a traumatic family situation (ie. parental loss, divorce, separation, severe parental illness)? Yes  No  If yes, at what age: \_\_\_\_\_

Has anyone in the immediate family or extended family had a learning problem? Yes  No

If yes, who? \_\_\_\_\_

**GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Today's Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Name of Parent/Legal Guardian:** \_\_\_\_\_

**Signature of Parent/Legal Guardian:** \_\_\_\_\_