CHILDREN'S VISION AND LEARNING QUESTIONNAIRE

Please fill out this questionnaire carefully.
Please email it to our office at least 2 days prior to your appointment. Thank you.

Appointment Date: _____
Appointment Time: _____
Patient's Name _____

GENERAL INFORMATION

1. Were you referred to our office? _____
   If yes, whom may we thank for this referral? _____
   Referral's Phone: _____
   Referral's Address: _____
2. Child's Full Name: _____
3. Birth Date: _____
4. Name and address of school: _____
   Grade: _____
   Teacher: _____
   School Nurse: _____
   Principal: _____
5. Is your child especially afraid of doctors? _____
6. Child's dominant hand (Right or Left)? _____
7. Has guidance been given in use of hands? _____
8. Please list the **names** and **ages** of your family:
   a. Father/Caretaker: _____ _____
   b. Mother/Caretaker: _____ _____
   c. Sibling: _____ _____
   d. Sibling: _____ _____
   e. Sibling: _____ _____

RESPONSIBLE PERSON(S) INFORMATION

1. Home Address: _____
2. Home Phone: _____
3. Father/Caretaker's Occupation: _____
   Business Address: _____
   Business Phone: _____
4. Mother/Caretaker's Occupation: _____
   Business Address: _____
   Business Phone: _____

LEARNING PROBLEMS HISTORY

1. Why would you like the child to be evaluated by this office? _____
2. At what age did the learning or reading problem begin? _____
3. Under what circumstances did the problem begin? _____
4. Has the problem become better or worse? Please explain: _____
5. Does anyone else in the family have a similar problem? _____
6. Have parents made any attempt to correct the problem at home? _____
   How? _____
   Results: _____
7. Was there previous therapy or tutoring? _____
8. Does the child feel that they have a problem? _____
9. If yes, what is the child's attitude toward the problem? _____
10. What is the attitude of family, relatives, and friends? _____
11. Do you feel your child is achieving up to their potential? _____
12. Does the teacher feel your child is working up to their potential? _____

SCHOOL ENVIRONMENT

1. Age at time of entrance to Kindergarten: _____
2. Age at time of entrance to First Grade: _____
3. Does the child like school? If no, please explain: _____
4. Has a grade been repeated? If yes, which? _____
5. Have there been any major school difficulties? If yes, please explain: _____
6. What subjects are the most difficult for the child? _____
7. Possible reasons for the difficulties? _____
8. Has attendance been regular? If no, please explain: _____
9. Please list all the **schools** the child has attended and the **dates** of attendance:

School	District	Date Attended

** Please arrange for a report card for the current or past year to be brought with you on the initial visit.

MEDICAL HISTORY

1. Pediatrician's Name: _____
2. Date of Last Evaluation: _____
3. For what reason? _____
4. Results and recommendations: _____
5. Child's current state of health: _____
6. Medications currently using, including vitamins and supplements: _____

   _____
7. Any allergic reactions to any medications? If yes, name of medication(s): _____

   _____
8. Is there any history of the following? (P) Patient / (F) Family: If family, who?
   a. High blood pressure _____ _____ b. Glaucoma _____ _____
   c. Diabetes _____ _____ d. Cataract _____ _____
   e. Thyroid Condition _____ _____ f. Blindness _____ _____
   g. Multiple Sclerosis _____ _____ h. Amblyopia (lazy eye) _____ _____
   i. Brain Tumor _____ _____ j. Chromosomal imbalance _____ _____
9. Other health problems? If yes, explain: _____
10. Are there any chronic problems like ear infections, asthma, hay fever, allergies? _____
    If yes, please list: _____

    _____
11. List illnesses, bad falls, concussions, high fevers, etc. (Age, Severe / Mild, Complications):

    _____

    _____

    _____
12. Has a neurological evaluation been performed? _____
    By whom? _____
    Results and recommendations: _____

    _____
13. Has a psychological evaluation been performed? _____
    By whom? _____
    Results and recommendations: _____

    _____
14. Has an occupational therapy evaluation been performed? _____
    By whom? _____
    Results and recommendations: _____

    _____

DEVELOPMENTAL HISTORY

1. Full-term pregnancy? _____
2. Did the mother experience any problems during pregnancy? _____

3. Normal birth? _____
4. Were forceps used? _____
5. Any complications before, during, or immediately following delivery? _____
6. Did your child crawl (stomach on floor)? _____
   At what age? _____
7. Did you child creep (stomach off floor?) _____
   At what age? _____
8. At what age did your child sit up (without support)? _____
9. At what age did your child walk (without support)? _____
10. First words: _____
    At what age? _____
11. At what age did your child speak in a simple sentence (string two words together)? _____
12. Was your child alert as an infant? _____
13. Were there ever any concerns regarding growth or development? If yes, explain: _____

_____

PREVIOUS VISION CARE / TREATMENTS

1. Has your child had a previous visual evaluation? _____
   Doctor's Name: _____
   Date of last visit: _____
   Results and recommendations: _____

   _____
2. Were glasses, contact lenses, or other optical devices ever prescribed? _____
   If yes, Bifocal / Single-vision / Contact lenses / Other ? _____
   Explain: _____
3. Are they used? _____
   If yes, when are they worn? _____
   If no, why not? _____
4. Are you here for a second opinion regarding any visual problems or further treatment? _____
   If yes, please explain: _____
5. Has there been any visual therapy? _____
   If yes, Dr's name: _____
6. Please describe the type of visual therapy, including its duration, the date at which it started, and an estimate of the results:

   _____

   _____

FAMILY AND HOME

1. Please indicate which adult(s) the child lives with: _____
2. Does your child spend time with any other person, not in the home? _____
   If yes, please explain: _____

3. Has your child ever been through a traumatic family situation (divorce, parental loss, separation, severe parental illness, etc.)? _____
   If yes, at what age: _____
4. Does your child seem to have adjusted? _____
5. Was counseling/therapy undertaken? _____
   If yes, is it on-going? _____
6. Is family life stable at this time? _____
   If no, please explain: _____

NUTRITIONAL INFORMATION

1. Current Diet: (Excellent, Good, Fair, Poor?) _____
2. Does your child **like** sweets or **crave** sweets? _____
   If yes, what types: _____
3. Are there any food allergies/sensitivities? _____
   If yes, explain: _____
4. Is your child active? (Yes, No, Moderately, Extremely) _____
5. Are there periods of very high energy? _____
6. Are there periods of very low energy? _____

COMPUTERS

1. Does your child play computer games? _____
   If yes, how many hours per day? _____
   How many days per week? _____
2. How many hours per week is your child's total screen time? _____

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

_____

_____

_____

_____

IS THERE ANY OTHER INFORMATION THAT WOULD BE IMPORTANT / USEFUL IN OUR TREATMENT OF YOUR CHILD?

_____

_____

_____

_____