Boulder Valley VISION THERAPY

CHILDRENS' VISION QUESTIONNAIRE

*Please fill complete this questionnaire and return it to our office **PRIOR** to your appointment when possible.*

Child's Name: _____

Birthdate: _____ Age: _____ years _____ months

GENERAL INFORMATION:
Whom may we thank for this referral? _____ Phone: _____

Address: _____

Name and address of school: _____
Grade: _____ Teacher(s): _____

Please list the names and birth dates of your family:
Father/Caretaker _____ Birth Date _____

Mother/Caretaker _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Preferred Contact Information (e-mail/ phone#): _____

MEDICAL HISTORY:
Pediatrician's Name: _____ Date of last Evaluation: _____
For what reason?_____
Child's Current state of health: _____
_____
Medications and vitamins/supplements: _____
Medical Conditions: _____
Are immunizations current? _____ Any reactions to immunizations? _____
Are there any chronic problems (ear infections, allergies, asthma)? _____
List illness, bad falls, high fevers, etc:

Age	Condition	Severity	Complications

Has a neurological evaluation been performed? No Yes, Results: _____
Has a psychological evaluation been performed? No Yes, Results: _____

Has an occupational therapy evaluation been performed? No Yes, Results and Recommendations:

_____

Check the box if there is a history of these conditions. List the family member with the condition:

Diabetes	No	Yes, _____	**Crossed Eyes**	No	Yes, _____
Seizures	No	Yes, _____	**Eyes drift out**	No	Yes, _____
ADD/ADHD	No	Yes, _____	**Lazy Eye(amblyopia)**	No	Yes, _____
Multiple Sclerosis	No	Yes, _____	**Strabismus**	No	Yes, _____
Developmental Delays	No	Yes, _____	**Other:**		_____
Chromosome Disorder	No	Yes, _____			_____
Learning Disability	No	Yes, _____			_____

NUTRITIONAL INFORMATION:

Current Diet: _____

Food Allergies: _____Typical Energy Level: _____

DEVELOPMENTAL HISTORY

Was this patient adopted? No Yes Full-term pregnancy: No Yes

List any pregnancy complications: _____

Normal birth: No Yes List any birth complications: _____

_____

Birth weight: _____ Apgar at birth: _____ Apgar at second check: _____

Any concern over general growth or development? _____

_____

Did your child creep (scoot on tummy)? No Yes At what age? _____

Did your child crawl (up on all fours)? No Yes At what age? _____

At what age did your child walk? _____ Any difficulty with speaking? No Yes

At what age did your child begin talking? _____ Is speech clear now? No Yes

VISUAL HISTORY

Has your child's vision been evaluated by an eye doctor? No Yes, Dr. _____

Date of last evaluation: _____ Reason for exam: _____

Results and recommendations: _____

Were glasses or contact lenses recommended? _____

Are they used? No Yes, when? _____

Is there a family history of vision problems? No Yes _____

List any complaints your child makes about their vision: _____

_____

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____

How long has this problem been observed? _____

Are there any testing results that have indicated a visual disorder? No Yes, _____

_____

Give a brief description of your child as a person: _____

_____

_____

_____

Does your child report any of the following?

Symptoms	Yes	If yes, when?	Symptoms	Yes	If yes, when?
Headaches			Eyes hurt		
Blurred vision			Eyes tired		
Focus goes in and out			Words move on page		
Double vision			Motion sickness		
Dizziness			Other complaints		

Have you or anyone else noticed any of the following?

Symptoms	Yes	If yes, when?	Symptoms	Yes	If yes, when?
Red eyes			Frequent blinking		
Frequent eye rubbing			Closing or covering one eye		
Frequent styes			Difficulty seeing at distance		
Frowning			Avoids reading		
Light sensitive			Head close to paper		
Prefers being read to			Tilts head when reading		
Moves head when reading			Vocalizes when reading silently		
Confuses letter or words			Tilts head when writing		
Confuses left and right			Loses place when reading		
Reverses letters or words			Skips or omits words		
Rereads words			Reads slowly		
Uses finger to keep spot			Poor reading comprehension		
Writes slowly			Writes poorly		
Comprehension decreases over time			Difficulty recognizing same word on the next page		
Tires easily			Frequent erasures		
Poor memory			Difficulty hitting a ball		
Dislikes sports			Difficulty catching a ball		
Difficulty with scissors			Poor fine motor skills		
Short attention span			Poor large motor skills		
Avoids near tasks			Poor test performance		
Remembers better what hears than sees			Poor eye-hand coordination		

LEISURE ACTIVITIES

How much TV does your child watch? _____ Viewing distance? _____
How much time on computer? _____ Playing video games? _____
What activities does your child enjoy? _____
Are there activities that your child would like to participate in, but doesn't? _____
_____

SCHOOL

Age of time of entrance to: preschool _____ Kindergarten _____ First grade _____
Does your child like school? No Yes Has your child changed schools often? No Yes
Describe any school difficulties: _____
_____
Has a grade been repeated? No Yes, why_____
Does you child seem under tension or stress during school work? No Yes
Has your child had any tutoring therapy or remedial assistance? No Yes, _____
_____
Does your child like to read? No Yes Does your child read for pleasure? No Yes
What does your child enjoy reading? _____
What is your child's attitude toward school? _____
Which subjects are:
Above average: _____
Average: _____
Below average: _____
Does your child spend a lot of time and effort to maintain this level of performance? No Yes
How much time does your child spend on an average day of homework? _____
How much assistance do you give your child? _____
Is your child achieving up to their potential? No Yes
Does the teacher feel the child is performing at potential? No Yes
Are there any behavioral issues? _____
What is your child's reaction to stress? _____

FAMILY AND HOME

Who does your child live with? _____
Has your child been through a traumatic family situation? (divorce, loss, illness) No Yes
If yes, at what age? _____ Does your child seem to have adjusted? No Yes
Was counseling/therapy undertaken? No Yes, _____
How well does your child get along with peers and adults? _____

Is there any other information you feel would be helpful/important in our treatment of your child?

_____
_____
_____
_____
_____
_____
_____
_____