LAS VEGAS CENTER FOR VISION THERAPY
Vision Development & Rehabilitation

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Children's Vision Questionnaire

Please fill out this questionnaire carefully, and if possible, return it to our office prior to the appointment. Thank you.

General Information

Patient's Name: ____

Birth Date: ____/____/________ Age: ____ *years* ____ *months* Male ☐ Female ☐

Name of School: ____

Grade: _______ Teacher: ______________________________ School Nurse: ______________________________

Special Ed Teacher: ____________________ School Occupational Therapist: ______________________________

Home Address: ______________________________ City: ____________ State: ______ Zip: ____________

Home Phone: (________) ____________________

Parent/Guardian's Name: ____

Business Phone: (________) __________________ Cell Phone: (________) __________________

Occupation: ______________________________ Email: ______________________________

Parent/Guardian's Name: ____

Business Phone: (________) __________________ Cell Phone: (________) __________________

Occupation: ______________________________ Email: ______________________________

Sibling Name: ______________________________ Age: ________

Sibling Name: ______________________________ Age: ________

Sibling Name: ______________________________ Age: ________

Sibling Name: ______________________________ Age: ________

Were you referred to our office? ☐ Yes ☐ No If yes, whom may we thank for this referral? ______________________________

Address: ____ Phone Number: (_______) _______ - __________

Medical History

Pediatrician's Name: ____ Date of Last Visit: ____/____/________

For what reason? ____

Results & Recommendations: ____

____

Medications currently using, including vitamins and supplements: ______________________________

____

For what condition(s)? ____

____

List major illnesses or injuries and age of occurrence: ______________________________

____

____

Does/did your child have chronic ear infections: ☐ Yes ☐ No Asthma? ☐ Yes ☐ No

Hay fever/environmental allergies? ☐ Yes ☐ No Food allergies? ☐ Yes ☐ No

Please list specific allergies: ______________________________

Has a neurological evaluation been performed? ☐ Yes ☐ No

By whom? ______________________________ Results & Recommendations: ______________________________

____

Has a psychological/education or neuro-psychological evaluation been performed? ☐ Yes ☐ No

By whom? ______________________________ Results & Recommendations: ______________________________

____

Has a private occupational therapy and/or physical therapy evaluation been performed? ☐ Yes ☐ No

By whom? ______________________________ Results & Recommendations: ______________________________

____

Is there any history of the following (please check all that apply)?

	Patient	Family	Relationship		Patient	Family	Relationship
Diabetes	☐	☐	________	High Blood Pressure	☐	☐	________
"Cross" or "Wall" eye *(Eye Turn/Strabismus)*	☐	☐	________	Learning Disability	☐	☐	________
"Lazy" eye *(Amblyopia)*	☐	☐	________	Chromosomal Disorder	☐	☐	________
Multiple Sclerosis	☐	☐	________	Glaucoma	☐	☐	________
Epilepsy or Seizures	☐	☐	________	Other	☐	☐	________

If other, please explain: ______________________________

Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child active? ☐ Yes ☐ No Moderately? ☐ Yes ☐ No Excessively? ☐ Yes ☐ No

Does your child have periods of very high energy? ☐ Yes ☐ No Very low energy? ☐ Yes ☐ No

Explain: ______________________________

Developmental History

Full-term pregnancy? ☐ Yes ☐ No If no, how many weeks? ______________________________

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

If yes, please explain: ______________________________

Normal birth? ☐ Yes ☐ No Any complications before, during, or after delivery? ☐ Yes ☐ No

If yes, please explain: ______________________________

Birth weight: ______________________________ Decreased APGAR score? ☐ Yes ☐ No

Did you ever have a reason for concern regarding your child's general growth or development? ☐ Yes ☐ No

If yes, why? ______________________________

Did your child crawl (stomach on the floor)? ☐ Yes ☐ No At what age? ______ *months*

Did your child creep (on all fours, stomach off the floor)? ☐ Yes ☐ No At what age? ______ *months*

If not, please describe: ______________________________

At what age did your child walk? ______ *months*

Speech: First words: ____ At what age? ______ *months*

Was the early speech clear to others? ☐ Yes ☐ No Is speech clear now? ☐ Yes ☐ No

Visual history

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

If yes, doctor's name: ____ Date of last exam: ____/____/________

Reason for exam: ____

Results/Recommendations: ____

Were glasses, contact lenses, or other optical devices prescribed? ☐ Yes ☐ No

If yes, what was recommended? ____

Are they used? ☐ Yes ☐ No If yes, when? ____

If not used, why? ____

Please list any immediate family members who have had vision treatment, including reason for therapy: ___________________________________

____

Present Situation

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

____

____

____

____

____

How long has the problem/difficulty been observed? ____

Is there any evidence from school, psychological, or other testing that indicates some visual problem may be present? ☐ Yes ☐ No

If yes, please describe: ____

____

____

(continued on next page)

Check the column that best represents the occurrence of each symptom.

	Never	Seldom	Occasionally	Frequently	Always
Blurry vision when looking at near objects					
Double vision					
Headaches with near work *(reading, computer use, etc.)*					
Words run together or move when reading					
Burning, itchy, or watery eyes					
Falls asleep while reading					
Vision worse at the end of the day					
Skips/repeats lines when reading					
Dizziness/nausea with near work					
Head tilt/closing one eye when reading					
Difficulty copying from chalk/whiteboard					
Avoids near work/reading					
Omits small words when reading					
Writes uphill or downhill					
Misaligns digits/columns of numbers					
Reading comprehension decreased/poor					
Poor/inconsistent in sports					
Holds reading objects too close					
Trouble maintaining attention with reading					
Difficulty completing assignments on time					
Always says "I can't" before trying					
Avoids sports/games					
Poor hand/eye coordination and/or poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Does not use his/her time well					
Does not make change well					
Loses belongings or items					
Car/motion sickness					
Forgetful/poor memory					

Does your child report any of the following:	Yes	No	If yes, when?
Eyes Hurting	☐	☐	______________________________
Eyes Tired	☐	☐	______________________________

Have you noticed any of the following:			If yes, when?
Eyes frequently reddened	☐	☐	______________________________
Frequent eye rubbing	☐	☐	______________________________
Frequent blinking	☐	☐	______________________________
Moving head when reading	☐	☐	______________________________
Confusing of letters/words	☐	☐	______________________________
Reversal or letters/words	☐	☐	______________________________
Use of finger as a marker when reading	☐	☐	______________________________
Difficulty recognizing the same word on different page	☐	☐	______________________________
Difficulty with memory	☐	☐	______________________________
Responds better orally than by writing	☐	☐	______________________________
Better memory with hearing versus seeing	☐	☐	______________________________

Leisure Time Activities

Does your child spend time watching TV? ☐ Yes ☐ No

If yes, how many hours per day? ________ Days per week? ________ Viewing distance? ________ *inches/feet*

Does your child spend time using a computer, iPad or tablet device, or playing video games? ☐ Yes ☐ No

If yes, how many hours per day? ________ Days per week? ________ Viewing distance? ________ *inches/feet*

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 the time of entrance to: Preschool: ______ *months* Pre-Kindergarten: ______ *years* Kindergarten: ______ *years* Grade 1: ______ *years*

Does your child like school? ☐ Yes ☐ No

Please describe any specific school difficulties: ____

____

____

____

Has your child changed schools often? ☐ Yes ☐ No If yes, when? ________________________________

Has your child repeated any grade? ☐ Yes ☐ No If yes, which grade and why? ________________________

Does your child seem to be under tension or extreme pressure when doing schoolwork? ☐ Yes ☐ No

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

If yes, when and for how long? ______________________________

Where and from whom? ______________________________

Results: ______________________________

Does your child like to read? ☐ Yes ☐ No Does s/he read voluntarily? ☐ Yes ☐ No

Does your child read for pleasure? ☐ Yes ☐ No If so, what does s/he read? ______________________________

What is your child's attitude towards reading, school, his/her teachers, peers? ______________________________

____

Overall, schoolwork is: ☐ Above Average ☐ Average ☐ Below Average

Which subjects are

Above Average: ______________________________

Average: ______________________________

Below Average: ______________________________

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

How much time does your child spend each day on homework? ______________________________

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

Does your child's teacher feel that your child is achieving up to potential? ☐ Yes ☐ No

General Behavior

Does your child have behavioral problems at school? ☐ Yes ☐ No

If yes, please describe: ______________________________

Does your child have behavioral problems at home? ☐ Yes ☐ No

If yes, please describe: ______________________________

What causes these problems? ______________________________

What is your child's reaction to fatigue? ______________________________

What is your child's reaction to tension? ______________________________

Does your child say and/or do things impulsively? ☐ Yes ☐ No

Does your child seem to be in constant motion? ☐ Yes ☐ No Can your child sit still for long periods? ☐ Yes ☐ No

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

If yes, please explain: ______________________________

Has your child ever been through a traumatic family situation (*e.g.,* divorce, parental loss, separation, severe parental illness)? ☐ Yes ☐ No

If yes, at what age? __________ Briefly explain: ______________________________

____

Does your child seem to have adjusted? ☐ Yes ☐ No

Is family life stable at this time? ☐ Yes ☐ No

If no, please explain: ______________________________

Did a parent or anyone in the parent's family have a learning problem? ☐ Yes ☐ No

If yes, who? ______________________________

Do any or did any of the other children in the family have learning problems? ☐ Yes ☐ No

If yes, who and to what extent? ______________________________

____

Please give a brief description of your child as a person: ______________________________

____

____

____

____

____

Please provide any additional information you feel would be helpful and/or important in our evaluation of your child:

____

____

____

____

____

Parent/Guardian Preference Regarding Communication with Our Office

It is often beneficial for us to discuss examination results and to exchange information with ***your child's school, pediatrician, and/or other professionals*** involved in his/her care. Please provide the information and sign below to authorize this exchange of information.

I hereby give my permission for information from, or copies of, the examination records of my child, ______________________________, to be forwarded to other health care providers when it is necessary for the treatment of my child's visual condition. I further authorize representatives of the Las Vegas Center for Vision Therapy to exchange information with my child's school and other professionals involved in my child's care. The professionals are listed below. This authorization shall be valid for the duration of treatment or until a written request to the contrary is received.

Name: ______________________________ Relation: ______________________________

Address: ______________________________ City: ____________________ Zip: ____________

Name: ______________________________ Relation: ______________________________

Address: ______________________________ City: ____________________ Zip: ____________

Name: ______________________________ Relation: ______________________________

Address: ______________________________ City: ____________________ Zip: ____________

In addition, if you prefer, we may discuss examination results and exchange information with ***your child's family member(s) and/or friend(s)*** who are involved in his/her care. Please provide the information and sign below to authorize this exchange of information.

I hereby give permission to the Las Vegas Center for Vision Therapy to disclose and discuss any information related to my child's visual and medical condition(s) with the following family member(s) and/or friend(s):

Name: ______________________________ Relation: ______________

Name: ______________________________ Relation: ______________

Name: ______________________________ Relation: ______________

Name: ______________________________ Relation: ______________

How should we contact you?

- □ Home phone
- □ Work phone
- □ Cell phone
- □ Home fax
- □ Work fax
- □ Cell phone Text

If we cannot reach you by telephone,

- □ Leave a message with details, including health information
- □ Leave a message with call back number only

If you provide your email address, we may contact you via email for appointment reminders, sending reports, and general correspondence. Emails are sent from our secure system; we will not send health information if you request us to do so.

The information provided on this questionnaire is current and correct to the best of my knowledge, and I hereby give my permission to the doctors and therapists at Las Vegas Center for Vision Therapy to treat my child.

______________________________ ______________ ____/____/________

Signature of patient (or parent/legal representative) *Relationship to patient* *Date*

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs. If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us on our secure voicemail or email. We request a minimum of 24 hours notice if you are unable to keep this appointment. Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status.