**Strasburg Vision and Learning Center**
**717-687-8141**

# Children's Vision Questionnaire

**Please fill out this questionnaire *carefully*. Please complete and return. Thank you!**

## GENERAL INFORMATION

Child's Full Name_____ Age_____Birth Date_____ Male___ Female___

School_____ School Address_____

_____

Grade_____ Teacher_____ Principal_____

Is your child especially afraid of doctors? Yes___ No___

Were you referred to our office? Yes___ No___ If yes, whom may we thank? _____

Address _____

Names of Parents or Legal Guardians_____

## MEDICAL HISTORY

Date of most recent medical examination_____ Doctors Name_____

Reason:_____ Results_____

Child's current state of health_____

Medications currently using, including vitamins and supplements_____

_____

For what condition(s)?_____

List illnesses, bad falls, head injuries, high fevers, etc._____

Complications and ages: _____

Is your child generally healthy? Yes___ No ___

Are there any chronic problems like asthma, hay fever, allergies? Please List_____

_____

Has a neurological evaluation been performed? Yes___ No ___ By Whom? _____

Results:_____

Has a psychological evaluation been performe? Yes___ No ___ By Whom? _____

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Results_____

Does your child currently receive:

Physical therapy services? Yes___ No ___ By Whom? _____

Results_____

Occupational therapy services? Yes___ No___ By Whom?_____

Results_____

Speech therapy services? Yes___ No ___ By Whom?_____

Results_____

Is there any history of the following:

| | Patient | Family Who? | | Patient | Family Who? |
|---|---|---|---|---|---|
| Diabetes | _____ | _____ | Glaucoma | _____ | _____ |
| Eye turn | _____ | _____ | Amblyopia | _____ | _____ |
| MS | _____ | _____ | Seizures | _____ | _____ |

Any other conditions?_____

Is your child: Moderately active_____ or Extremely Active ____

Are there periods of very high energy: Yes____ No ____ Low Energy? Yes____ No ____

## DEVELOPMENTAL HISTORY

Full term pregnancy? Yes____ No ____ Normal Birth? Yes____ No ____ Birth Weight_____

Any complications before, during or immediately after delivery? Yes___ No___, Explain_____

At what age did your child walk?_____ Was child active?_____

First words at what age?_____

Was speech clear to others? Yes___ No ___ Is it clear now? Yes____ No ____

Which is your child's dominant hand? Right____ Left____

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## VISUAL HISTORY

Date of last eye exam_____ Doctor's name_____

Results_____

Were glasses prescribed? Yes____ No ____ Are they worn? Yes____ No____ For near, or distance or both?_____

## PRESENT SITUATION

List any complaints your child makes concerning his/her vision_____

_____

Television viewing: How much? _____ How often? _____ Viewing distance_____

Video game playing: How much? _____ How often? _____Viewing distance_____

Are there any activities your child would like to participate in but doesn't? Please explain:_____

_____

## ACADEMIC HISTORY

Age at time of entrance to Kindergarten_____

Does child like school? Yes___ No ___ Teacher? Yes___ No ___

School work is: Above Average_____ Average_____ Below Average_____

Does your child spend a lot of time and 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 help your child with homework? _____

Do you feel your child is achieving up to his/her potential? Yes___ No ___

Does the teacher feel your child is achieving up to his/her potential? Yes___ No___

Does your child like to read? Yes___ No ___ Voluntarily? Yes___ No___

Indicate any problems in the following areas:

| | | | |
|---|---|---|---|
| | ___ Reading | ___ Comprehension | ___ Reversals |
| / | ___ Writing | ___ Avoidance of school work | ___ Motivation/Behavior |
| | ___ Overly Active | ___ Low self-esteem | ___ Math |
| | ___ Poor Memory | ___ Spelling | ___ Attention/Concentration |

___ Slow work ___ Other_____

Has a grade been repeated? Yes___ No___ Which? _____

Dos he/she seem to be under extreme tension or pressure when doing school work? Yes___ No ___

List any past or current help, training or tutoring utilized for the above problems:

_____

## GENERALY HISTORY

Please list any behavior problems at:

School_____ Home _____

What causes these problems? _____

Child's reaction to fatigue: Sad____ Irritable____ Other_____ Impulsive? Yes___ No ___

Constant motion? Yes___ No ___

## FAMILY AND HOME

Please indicate which adults he/she lives with? Mother____ Father____ Stepmother____ Stepfather_____ Foster_____

Parents ____ Grandmother____ Grandfather ___ Aunt ____ Uncle ___ Other caretaker_____

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

Please explain: _____

Has your child been through a traumatic family situation (such as divorce, parental illness)? Yes ___ No ___

Please explan_____

Was therapy undertaken? Yes ___ No___

Is it still ongoing? Yes___ No ___

If no explain _____

How does he/she get along with:

Parents_____

Siblings_____

Classmates_____

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Playmates_____

Give a brief description of your child as a:

Person_____

_____

_____

Please provide any additional information you feel would be helpful in our treatment of your child:_____

_____

_____