Initial Vision Questionnaire For 18 & Under

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 _____

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? _____

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: _____
_____
_____