Upstate Vision Therapy

Children's Vision Questionnaire

Please complete this form carefully and return it to our office prior to your appointment.

Appointment: Day _____ Date _____ Time _____

Patient's Name: _____

General Information

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

Date of Birth _____ Age _____ years, _____ months
Name and address of school _____
Grade _____ Teacher _____
School Nurse _____
Is your child afraid of doctors? Yes No Dominant hand: Right Left

Responsible Person Information

Home Address _____
City _____ ZIP _____ Phone ( )_____

Father/Caretaker's Employer _____ Business Phone _____
Mother/Caretaker's Employer _____ Business Phone _____

Medical History

Pediatrician's Name _____ Last visit _____
For what reason? _____
Results and recommendations _____
Child's current state of health _____
Medications currently using including vitamins and supplements _____
_____
For what conditions? _____
Any reactions to immunizations? Yes No Explain _____
List illnesses, bad falls, high fevers, etc. _____

Is your child generally healthy? Yes No Explain _____

Upstate Vision Therapy

Are there any chronic problems like ear infections, asthma, allergies? _____
Has a neurological evaluation been performed? Yes No
By who and results? _____

Has a psychological evaluation been performed? Yes No
By who and results? _____

Has an occupational therapy evaluation been performed? Yes No
By who and results? _____

Is there any history of the following and who?

Diabetes	_____	Amblyopis	_____
"Cross or Wall" eye	_____	Seizures	_____
Learning Disability	_____	Other	_____

Nutritional Information

Current diet:	Excellent	Good	Fair	Poor
Does your child:	Like sweets	Crave sweets		
Is your child active?	Moderately	Extremely		

Are there periods of
Very high energy? Yes No Very low energy? Ye No
Explain _____

Developmental History

Full Term Pregnancy? Yes No APGAR scores _____
Did the mother have any health problems during pregnancy? Yes No

Normal birth? _____

Did your child crawl (stomach on floor)? Yes No Age _____
Did your child creep (on all fours)? Yes No Age _____
At what age did your child walk? _____ Active or Quiet
Speech (first words) _____ Age _____
Was early speech clear to others? Yes No Is speech clear now? Yes No

Upstate Vision Therapy

Visual History

Doctor's name _____ Date of last exam _____
Reason for examination? _____
Results and recommendations_____
Were glasses, contact lenses or other optical devices recommended? Yes No
Are they used? Yes No If yes, when? _____
If no, why not? _____
Members of family who have had visual attention and reason?

Name	Age	Reason

Why do you feel your child needs a vision therapy evaluation? _____
_____
How long has this problem/difficulty been observed? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes No _____

Please discuss with your child:

Headaches	Yes	No	_____
Blurred vision/focus goes in and out	Yes	No	_____
Double vision	Yes	No	_____
Eyes hurt	Yes	No	_____
Words move around on the page	Yes	No	_____
Motion sickness/car sickness	Yes	No	_____
Dizziness	Yes	No	_____

Have you or anyone else ever noticed the following:

Eyes frequently reddening	Yes	No	_____
Frequent eye rubbing	Yes	No	_____
Frequent sties	Yes	No	_____
Frowning	Yes	No	_____
Bothered by light	Yes	No	_____
Frequent blinking	Yes	No	_____

Upstate Vision Therapy

Closing or covering one eye	Yes	No	_____
Difficulty seeing distant objects	Yes	No	_____
Head close to paper when reading	Yes	No	_____
Prefers being read to	Yes	No	_____
Tilts head when reading	Yes	No	_____
Tilts head when writing	Yes	No	_____
Moves head when reading	Yes	No	_____
Confuses letter or words	Yes	No	_____
Reverses letter or words	Yes	No	_____
Confuses right and left	Yes	No	_____
Skips, rereads or omits words	Yes	No	_____
Loses place when reading	Yes	No	_____
Vocalizes when reading silently	Yes	No	_____
Reads slowly	Yes	No	_____
Uses finger as a marker	Yes	No	_____
Poor reading comprehension	Yes	No	_____
Comprehension decreases over time	Yes	No	_____
Writes or prints poorly	Yes	No	_____
Writes neatly but slowly	Yes	No	_____
Does not support paper when writing	Yes	No	_____
Awkward or immature pencil grip	Yes	No	_____
Frequent erasures	Yes	No	_____
Tires easily	Yes	No	_____
Difficulty copying from board	Yes	No	_____
Difficulty recognizing same work on different page	Yes	No	_____
Difficulty with memory	Yes	No	_____
Remembers better what hears than sees	Yes	No	_____
Responds better orally than by writing	Yes	No	_____
Seems to know material, but scores poorly on tests	Yes	No	_____
Dislikes/avoids near tasks	Yes	No	_____
Short attention span/loses interest	Yes	No	_____
Poor large motor coordination	Yes	No	_____
Poor fine motor coordination	Yes	No	_____
Difficulty with scissors	Yes	No	_____
Dislikes/avoids sports	Yes	No	_____
Difficulty catching/hitting a ball	Yes	No	_____

Upstate Vision Therapy

Television/Leisure Activities

Does your child watch TV? Yes No How much? _____ Viewing distance____'
Does your child spend time using computer/video games? Yes No
How much? _____ Viewing distance _____
What other activities occupy your child's time? _____
Are there any activities your child would like to participate in, but doesn't? Yes No
Explain _____

School

Age at time of entrance to pre-school _____ Kindergarten _____
Does your child like school? Yes No
Specifically describe any school difficulties _____

Has your child changed schools often? Yes No
If yes, when? _____
Has a grade been repeated? Yes No
If yes, which and why? _____
Has your child had any special tutoring, therapy, and or remedial assistance? Yes No
If yes, when? _____
With whom? _____
How long? _____
Results: _____
Does your child like to read? Yes No
Voluntarily? Yes No Does your child read for pleasure? Yes No
Overall schoolwork is: Above average Average Below average
Which subjects are:
Above average _____
Average _____
Below average _____
How much time does your child spend on homework? _____
How much help are you providing? _____
Do you feel your child is achieving up to potential? Yes No
Does your child's teacher think that your child is achieving up to potential? Yes No

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

Upstate Vision Therapy

Release of Information

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

I agree to permit information from or copies of my child's examination records to be forwarded to my child's school and any other health care providers upon their request or upon the recommendation of Dr. Billie P. Skinner and Upstate Vision Therapy when it is necessary for the treatment of my child's visual condition. This authorization shall be considered valid throughout the duration of treatment.

Signature _____ Date _____

Relationship to patient _____

Thank you for carefully completing this questionnaire. This information will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation.

If you have any questions or concerns that we may help answer prior to your appointment, please do not hesitate to call.

Thank you.

Dr. Billie P. Skinner
Upstate Vision Therapy