

Name _____ Date _____

Date of child's last eye examination _____ Has child ever had vision therapy? Yes No

Has Child ever worn glasses? Yes No Does he/she wear glasses now? Yes No
If yes: for distance only for near only wears them full time

Does child wear contact lenses? Yes No Any problems? _____

This is your opportunity to tell us about all areas of concern about your child's vision.

What is your main reason for coming here today? _____

Have you noticed any unusual signs or symptoms that concern you? _____

School-Related Vision Problems: Questions for parents:

Have any of your children had difficulty in school? Yes No

Please explain _____

How do you feel your child is doing in school? Well Below potential Poorly

Please check the signs and symptoms that best describe how your child is doing in school

- Does your child squint when looking up from reading?
- Have trouble seeing the chalkboard?
- Frequently blink or rub eyes?
- Have headaches after doing school work?
- Frequently awkward, bump into things, knock things over?
- Hold books extremely close?
- Read a great deal of the time?
- Report that things look blurry?
- Have trouble copying work from the chalkboard to paper?

- Spend a long time doing homework that should take only a few minutes?
- Reduced attention span, can concentrate for only a moderate time?
- Covers one eye by leaning on hand?
- Lays head on desk when doing pencil work?
- Frequently loses place when reading?
- Skips or re-reads words and lines?
- Reverses words or letters (was for saw, b for d) beyond second grade?
- Does better at math than English, history or social studies?
- Must re-read material several times to grasp its meaning?
- Gets tired quickly when doing reading or homework?

- Short attention span? Can concentrate on reading work for only a few minutes.
- Daydreams a lot? Stares off into the distance frequently?
- Learns best through auditory tactics (listens to learn)?
- Misbehavior has become a problem (to cover up poor school performance)?
 - Acts up when asked to do school work
 - Class clown, "goofs off"
 - Moody or depressed about school and life
 - Aggressive, hits or dominates other children
- Avoids work that includes reading or near seeing?
- Is more than 1 year behind group in reading-related skills?
 - Has poor posture? Slouches, slumps in chair?

RECREATION AND LEISURE: In what recreational activities does your child participate? (Circle) Read, baseball, basketball, soccer, swim, build models, sew, dance, perform, play an instrument.

Other recreational or sports activities? _____

Does your child wear protective eyewear for his/her sport? Yes No

Does your child use a computer at home? Yes No Number of hours daily _____