VISION THERAPY CENTER

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VISION AND LEARNING QUESTIONNAIRE

Please fill out this questionnaire carefully.

THANK YOU.

Appointment: Day _____ Date _____ Time _____
Child's Name: _____

GENERAL INFORMATION

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

Child's Full Name: _____
Male _____ Female _____
Birth Date: _____ Age: _____years _____months
Name and address of school: _____
Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____
Is your child especially afraid of doctors? _____
Child's dominant hand: ☐ right or ☐ left

Please list the names and birth dates of your family:

NAME

Father/Caretaker _____ Birth Date _____
Mother/Caretaker _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Father/Caretaker's Occupation: _____ Business Phone: _____
Father's Mobile Phone: _____ Email: _____
Business Address: _____ City: _____ Zip: _____
Mother/Caretaker's Occupation: _____ Business Phone: _____
Mother's Mobile Phone: _____ Email: _____
Business Address: _____ City: _____ Zip: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations:

_____
Child's current state of health: _____

Medications currently using, including vitamins and supplements:

_____
For what condition(s)?

_____
Immunizations child has received:
____ Current on all immunizations
____ Exempt from immunizations
____ Other
Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: _____

List illnesses, bad falls, high fevers, etc.:

Age	Severe	Mild	Complications

Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations:

_____
Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations:

_____
Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations:

_____
Is there any history of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
"Cross" or "Wall" eye	☐	☐	_____	Learning Disability	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Glaucoma	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
				Epilepsy or Seizures	☐	☐	_____
				Other	☐	☐	_____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does your child: Like sweets ☐ or crave sweets ☐
If yes, what types? _____
Is your child active? Yes ☐ No ☐
moderately? Yes ☐ No ☐
extremely? Yes ☐ No ☐
Are there periods of
very high energy? Yes ☐ No ☐
very low energy? Yes ☐ No ☐
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 ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight: _____ Were forceps used? Yes ☐ No ☐
Was there any reason for concern over your child's general growth or development? Yes ☐ No ☐.
If yes, why? _____
Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? _____
Did your child creep (on all fours)? Yes ☐ No ☐ At what age? _____
If not, describe: _____
At what age did your child walk? _____
Was child active? Yes ☐ No ☐
Speech: First words: _____ At what age: _____
Was 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 so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they used? Yes ☐ No ☐ If yes, when? _____
If not used, why not? _____

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation

PRESENT SITUATION

Why do you feel your child needs a visual 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 ☐

If yes, what?

_____

DOES YOUR CHILD EVER REPORT ANY OF THE FOLLOWING?

	Yes	No	If yes, when?
Headaches	☐	☐	_____
Blurred vision / focus goes in and out	☐	☐	_____
Double vision	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes tired	☐	☐	_____
Words move around on the page	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____
Dizziness	☐	☐	_____

List any other complaints your child makes concerning his/her vision:

_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

APPEARANCE OF EYES			
Reddened eyes or lids	☐	☐	_____
Frequent blinking	☐	☐	_____
Eyes tear easily	☐	☐	_____
Frequent sties	☐	☐	_____
REFRACTIVE ERROR OR FOCUSING (ACCOMMODATIVE) PROBLEM			
Frowning	☐	☐	_____
Avoids reading	☐	☐	_____
Fatigues easily during near tasks	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Complains of blurred vision at near	☐	☐	_____
Difficulty seeing distant objects	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Head close to paper when reading or writing	☐	☐	_____
EYE TRACKING PROBLEM			
Skips, rereads or omits words	☐	☐	_____
Re-reads entire lines of print	☐	☐	_____
Confuses words with similar endings/beginnings	☐	☐	_____
Uses finger when reading	☐	☐	_____
Loses place easily when reading	☐	☐	_____
Moves head when reading	☐	☐	_____
Reads slowly	☐	☐	_____
Comprehension decreases over time	☐	☐	_____

	Yes	No	If yes, when?
EYE TEAMING (BINOCULARITY) PROBLEM			
Complains of seeing double	☐	☐	
Closing or covering one eye	☐	☐	
Eye turns in, out, up or down at any time	☐	☐	
Tilts head when reading	☐	☐	
Tilts head when writing	☐	☐	
Complains of words moving on the page	☐	☐	
Bothered by light	☐	☐	
Squints when reading	☐	☐	
Reports confusion of what is seen	☐	☐	
Tires easily	☐	☐	
Poor word attack skills	☐	☐	
Dislikes / avoids near tasks	☐	☐	
VISUAL INFORMATION PROCESSING PROBLEM			
Confuses letter or words	☐	☐	
Reverses letter or words	☐	☐	
Confuses right and left	☐	☐	
Difficulty copying from chalkboard	☐	☐	
Difficulty recognizing same word on different page	☐	☐	
Difficulty with memory	☐	☐	
Poor recall of visually presented tasks	☐	☐	
Remembers better what hears than sees	☐	☐	
Responds better orally than by writing	☐	☐	
Seems to know material, but does poorly on tests	☐	☐	
Short attention span / loses interest	☐	☐	
Vocalizes when reading silently	☐	☐	
School performance not up to potential	☐	☐	
EYE-HAND COORDINATION			
Writes or prints poorly	☐	☐	
Writes neatly but slowly	☐	☐	
Does not support paper when writing	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequent erasures	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulty with scissors / small hand tools	☐	☐	
Dislikes / avoids sports	☐	☐	
Difficulty catching / hitting a ball	☐	☐	

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
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 ☐
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? _____
Does your child seem to be under tension or extreme pressure
when doing school work? Yes ☐ No ☐
Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____
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 youngsters?

_____
Overall schoolwork is: above average ☐ average ☐ below average ☐
WHICH SUBJECTS 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 problems at school? Yes ☐ No ☐
If yes, what? _____
Are there any behavior problems at home? Yes ☐ No ☐
If yes, what? _____
What causes these problems? _____
Child's reaction to fatigue? sag ☐ irritable ☐ other ☐ _____
Child's reaction to tension? avoidance ☐ irritable ☐ other ☐ _____
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐
Can your child sit still for long periods? Yes ☐ No ☐

FAMILY AND HOME

Please indicate which adult(s) he/she lives with? Mother ☐ Father ☐ Stepmother ☐
Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caretaker (please specify): _____
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 (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐
If yes, at what age: _____
Does your child seem to have adjusted? Yes ☐ No ☐
Was counseling /therapy undertaken? Yes ☐ No ☐
If yes, is it on-going? Yes ☐ No ☐
Is family life stable at this time? Yes ☐ No ☐
If no, please explain: _____
How does your child get along with:
Parents/other caretakers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____

Did father or anyone in father's family have a learning problem? Yes ☐ No ☐
If yes, who? _____
Did mother or anyone in mother'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? _____
To what extent?

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions on concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day /7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examinations, so that we will have the maximum opportunity to evaluate your child's visual status.

THANK YOU.

Dr. Melanie McCarty Thompson
Developmental Optometrist

Dr. Melanie does not participate with any insurance company. She feels that her time is best spent focused on her patients' care and well being than on the endless red tape required by many insurance plans. Most medical insurances exclude Optometric Vision Therapy coverage, in the same way they exclude Orthodontics.

While Optometric vision therapy is not inexpensive,
it should be seen as an investment in your child's future.

Realizing that the cost of vision therapy may be a financial burden for some families, Dr. Melanie has made special arrangements with CareCredit.

Please do not hesitate to discuss this with her.

SAVE FORM