

**OPTOMETRISTS
CONTACT LENS PRACTITIONERS
BEHAVIOURAL OPTOMETRY
CHILDREN'S VISION**



Strachan Eyecare

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PARENT QUESTIONNAIRE

We would appreciate if the following form regarding your child could be filled in and returned to either practice *prior* to the scheduled examination on

If this is not possible please ensure that you bring the form along with you to that appointment. This information will make it possible for better use of our practice time as well as allowing you plenty of time to think of any questions you would like to ask us.

For primary children, it would also be helpful if you could ask your child's teacher to fill in the accompanying "TEACHER CHECKLIST" and return it together with this form and any copies of reports relevant to your child's development *prior* to this scheduled examination.

GENERAL INFORMATION

Child's name Preferred name (if different) Date of birth
Home address Phone
Parent's name(s)
Sibling's name(s) and age(s)
School name & suburb
Teacher's name Grade
Were you referred here? By whom?
What is the reason for this examination?
.....

SIGNS AND SYMPTOMS

The following signs and symptoms may indicate a visual problem. Please circle and/or place a tick next to any of the signs below that seem to occur often with this student (or may have been a concern in earlier years): -

- | | |
|---|--------------------------|
| Complains of blurry/double vision/glare/words "moving" when looking at the blackboard, reading or writing | <input type="checkbox"/> |
| Complains of sore/tired eyes; rubs/blinks eyes often | <input type="checkbox"/> |
| Eyes often red/watery after reading | <input type="checkbox"/> |
| Child is very tired at end of school day | <input type="checkbox"/> |
| Complains of headaches after near activities | <input type="checkbox"/> |
| Inattentive/short attention span with near tasks | <input type="checkbox"/> |
| Trouble learning left from right | <input type="checkbox"/> |
| Reverses letters/numbers/words | <input type="checkbox"/> |
| Trouble learning letters and their sounds | <input type="checkbox"/> |
| Trouble learning basic sight words | <input type="checkbox"/> |
| Can't recognize the same word repeated on a page | <input type="checkbox"/> |
| Mistakes words with similar beginnings | <input type="checkbox"/> |
| Trouble with mental arithmetic/spatial concepts | <input type="checkbox"/> |
| <input type="checkbox"/> Peers or squints/turns head to side to see | <input type="checkbox"/> |
| <input type="checkbox"/> One eye turns in or out when tired | <input type="checkbox"/> |
| <input type="checkbox"/> Covers or closes one eye when reading | <input type="checkbox"/> |
| <input type="checkbox"/> Holds books very close reading/writing | <input type="checkbox"/> |
| <input type="checkbox"/> Avoids near work | <input type="checkbox"/> |
| <input type="checkbox"/> Loses place reading/uses finger as marker | <input type="checkbox"/> |
| <input type="checkbox"/> Skips words often when reading | <input type="checkbox"/> |
| <input type="checkbox"/> Poor reading comprehension | <input type="checkbox"/> |
| <input type="checkbox"/> Copying errors from board to book | <input type="checkbox"/> |
| <input type="checkbox"/> Poor handwriting | <input type="checkbox"/> |
| <input type="checkbox"/> Slow to complete written work | <input type="checkbox"/> |
| <input type="checkbox"/> Poor spelling | <input type="checkbox"/> |

EDUCATIONAL HISTORY

Does your child like school? Reading?
Is your child's self esteem: Adequate/ Lacking?
Is schoolwork overall: Average / Better than average / Below average
Does your child have particular difficulty with: Reading Handwriting Spelling Maths
Were learning problems evident before school or in the first year of school or did they appear more recently?
.....
Has a grade been repeated? Grade?
Has any extra remedial work/tutoring been done? By whom?
Has your child had an assessment by an Educational Psychologist?..... Results?
.....

DEVELOPMENTAL AND MEDICAL HISTORY

Full term pregnancy?..... Birth weight less than 2.5kg(5lb)?.....
Any complications during pregnancy, at delivery or immediately following delivery?.....
.....
History of infantile seizures?
Any delay in gaining developmental milestones? ie. sitting up, crawling, walking, talking etc.....
.....
Was your child's early speech clear to others?.....
History of recurrent ear infections or "glue" ear?..... Have tubes been inserted?
Normal hearing?..... Assumed/Formally tested? If formal testing has been done, were auditory processing problems identified?..... Short term auditory memory?..... Background noise?
Has your child had Occupational Therapy, Physiotherapy, Speech Therapy or any other remedial therapy?

Would you describe your child as more an "indoors" or "outdoors" child?
Does your child enjoy sport? Are there any sports your child excels in?.....
Are there any sports your child does poorly in? Is your child inclined to be clumsy?.....
Do you consider your child's **gross** motor co-ordination (e.g. running, skipping, riding a bike, swimming, ball sports) to be:
above average *average* *below average* for their age?

Does your child enjoy: drawing art/craft puzzles construction toys
Do you consider your child's **fine** motor co-ordination (e.g. pencil-paper skills, cutting with scissors, threading, tying laces) to be:
above average *average* *below average* for their age?
Is your child strongly right/left or "both" handed? Was your child slow to establish a preferred hand?.....
.....
Has your child had any individual or formal music instruction?

Please circle if your child has had particular difficulty learning:- nursery rhymes, songs, the alphabet, counting, tables, time concepts, or has difficulty following more than one instruction at a time
Are there any behaviour problems? School Home
Does your child exhibit pronounced attention/concentration problems?.....
Has your child been diagnosed with Attention Deficit (Hyperactivity) Disorder ie. ADD or ADHD?.....
History of asthma, eczema, allergies, diet sensitivities?
Please list any past major illnesses or injuries:
.....
How would you describe your child's current general health?
Are any medications currently being taken?

VISUAL AND FAMILY HISTORY

Have your child's eyes previously been examined? When?
Where? Optometrist/Ophthalmologist?.....
Has your child ever worn glasses, undergone eye surgery, or Vision Therapy?.....
.....
Please indicate if family members have had significant visual problems:
.....
Please indicate if family members have had significant learning difficulties:
.....

Thank you for providing the above information, which will of course remain strictly confidential.

The initial consultation scheduled for your child will assess basic ocular and visual efficiency skills. If indicated, a second consultation will be recommended to assess your child's *developmental visual perceptual skills* or *"visual information processing skills"* which are very important in regards to early academic learning.
Any recommended treatment such as glasses or a Vision Therapy program will then be discussed with your Optometrist.

