OPTOMETRISTS
CONTACT LENS PRACTITIONERS
BEHAVIOURAL OPTOMETRY
CHILDREN'S VISION

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EyecarePlus
YOUR VISION – OUR FOCUS

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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 ……
Parent's name(s) & phone .....
Email ……
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			☐
Complains of sore/tired eyes; rubs/blinks eyes often	☐	Peers or squints/turns head to side to see	☐
Eyes often red/watery after reading	☐	One eye turns in or out when tired	☐
Child is very tired at end of school day	☐	Covers or closes one eye when reading	☐
Complains of headaches after near activities	☐	Holds books very close reading/writing	☐
Inattentive/short attention span with near tasks	☐	Avoids near work	☐
Trouble learning left from right	☐	Loses place reading/uses finger as marker	☐
Reverses letters/numbers/words	☐	Skips words often when reading	☐
Trouble learning letters and their sounds	☐	Poor reading comprehension	☐
Trouble learning basic sight words	☐	Copying errors from board to book	☐
Can't recognize the same word repeated on a page	☐	Poor handwriting	☐
Mistakes words with similar beginnings	☐	Slow to complete written work	☐
Trouble with mental arithmetic/spatial concepts	☐	Poor spelling	☐

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.....

.....

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 .....

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? .....

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, climbing) 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 Occupational Therapy, Physiotherapy, Speech Therapy or any other remedial therapy? .....

.....

Has your child had any individual or formal music instruction? .....

Are there any social or behaviour problems? School / home .....

Has your child been diagnosed with Autism Spectrum Disorder ie. ASD?.....

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? .....

History of tonsil infections/ sleep problems.....

Please list any other 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.

SUE STRACHAN GREG STRACHAN JACKY WU PETRA HURLESTON CHRISTA SIPOS-ORI HANA KHOO DANIEL STRACHAN