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PARENT QUESTIONNAIRE

This questionnaire was designed to help our office better understand <u>you</u>/<u>your child's</u> health history, general development, and learning skills. We have chosen to address the questions to the parent or guardian of a <u>child</u>, but if <u>you</u> are the patient, please disregard references to "the child" and tell us about <u>yourself</u>. If a question is not applicable to your child, please write N/A. If more space is needed, use back of page.

FAMILY INFORMATION Today's Date:_____

Child's name: _____Age:____ Date of birth: _____/_____/_____
Parent #1 name, address & phone(s):_____
Parent #2 name, address & phone(s): _____
Parent #1 occupation:_____ Parent #2 occupation:_____
Does this child live with both parents together, or one parent, or split time?_____
Siblings: name(s) & age(s) _____
Name of school: _____Grade: _____Teacher's name:_____
Previous schools/years:_____
Who may we thank for referring you to our office? _____

REASON FOR VISION APPOINTMENT

Why are you bringing your child for a vision evaluation? Are there problems with progress in school?

_____
_____
_____

What has been done to address this/these problem(s)? _____
_____

Has your child ever been diagnosed/labeled: (circle) "Dyslexic" "Learning Disabled" "Attention Deficit" "Developmentally delayed" "Tactile Defensive" Poor Motor Coordination: Fine/Gross "Hyperactive" "Autistic"/PDD Visual Perceptual Deficits Other/Comments: _____
_____

Do/Did any other family members suffer from similar difficulties? _____
_____

Please indicate if your child is having difficulty or is gifted in any of the following subjects:

Subject	Difficulties	Average	Gifted	Comments
Reading – Speed/Comprehension	____/____	___/___	___/___	_____
Reading – Sight words/ Phonics	____/____	___/___	___/___	_____
Handwriting	_____	_____	_____	_____
Spelling	_____	_____	_____	_____
Composition & Creative Writing	_____	_____	_____	_____
Art / Music	____/____	___/___	___/___	_____
Math	_____	_____	_____	_____
Working Independently	_____	_____	_____	_____
Social Interaction	_____	_____	_____	_____
Sports	_____	_____	_____	_____

Please give us a brief description of your child. _____

_____

_____

_____

_____

HEALTH HISTORY

Please describe the pregnancy and birth of this child:_____

_____

List major illnesses/recurrent illness/high fevers:_____

List any significant injuries or physical limitations:_____

List any allergies (known or suspected) and treatment:_____

List any current medical treatment, including medication:_____

Has this child ever had a seizure? Please describe:_____

Comments are welcome:

0= Not at all 1= Sometimes 2 = Very true #=Used to	0	1	2	#
Low level of energy				
Frequent colds/recurrent sinus congestion or nasal drip				
Breathes only/mostly through the mouth				
Sleeps poorly; or strongly resists sleep (circle)				
Persistent bed wetting				

SOCIAL – EMOTIONAL DEVELOPMENT

Please describe any significant changes or stressors in the family in the last months or years:_____

_____

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Low self esteem; poor self image				
Temper flare ups; aggressiveness				
Difficulty getting along with peers				
Easily frustrated; perfectionist; gives up easily				
Very shy; very uncomfortable in new situations				
Prone to depression				
Prone to anxiety				

RECEPTIVE AND EXPRESSIVE LANGUAGE; AUDITORY PROCESSING

Is more than one language spoken at home? _____

Did your child suffer from recurrent ear infections, or any other ear problems? Did you or your doctor ever suspect that your child could not hear well? Please explain._____

_____

Please describe your child's early expressive language. Were his/her words easily understood? Was speech therapy ever recommended/done?_____

_____

Please describe his/her current expressive and receptive language skill and vocabulary._____

_____

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Not precise with expressing ideas				
Tends to talk excessively (&/or) excessively loud (circle)				
Tends to talk too little (&//or) excessively soft (circle)				
Often mistakes what he/she hears – confuses similar words				
Seems to "strain" to listen and understand				
Listens inattentively				
Listens attentively yet often forgets what was said				
Difficulty following through with multi-step chores or school tasks				

TACTILE

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Still puts many things in his/her mouth to explore them				
Distressed by dressing, face washing, hair washing or hair cut, fingernails cut				
Dislikes sand, finger-paint, paste, or similar materials				
Prefers to wear less clothing than others, or shirts with no sleeves or collar, or picky about fabrics & textures				
Avoids physical contact in play – even with friends				
Dislikes affectionate touch (pat on the shoulder, hug)				
Especially uneasy being approached from behind				
Wears *more* clothing than others – as if "padding"				
Has strong need to touch "everything"				

GROSS MOTOR COORDINATION / POSTURE

Please comment on your child's motor development and coordination. Note the age at which she/he began crawling and walking._____

_____

Has your child ever been referred to an occupational or physical therapist? What was the diagnosis or goal? Was therapy done?_____

_____

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Wore (or wears currently) leg brace(s) or orthotics				
Inconsistent or difficulty with sports performance				
Tends to be clumsy or awkward; drops things / trips				
Restless, difficulty sitting still				
Complains of back or neck pain				
Has a hunched back, head tilt, other posture asymmetry				
Usually slouches while sitting and / or standing				
Low physical stamina				
Dominant hand: (circle) Right Left Uses both				
Has difficulty following "Right and Left" directions				

FINE MOTOR AND WRITING SKILLS

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Difficulty with "finger tasks" such as tying shoe laces, scissors				
Has a tight or awkward pen/pencil grip				
Difficulty learning to write ABCs				
In writing – reverses letters and/or numbers				
Uneven handwriting – poorly spaced				
Difficulty writing on the line; writes uphill or downhill				
Orients drawings awkwardly on a page				
Misaligns numbers in math				

EYESIGHT / EYE COMFORT

Has your child ever had a full vision exam done by an eye doctor (not just a screening at school or at the pediatrician)?

Did the doctor make any recommendations? Were lenses prescribed? For what usage?

Was the Rx filled? Have they been worn regularly? _____

_____

_____

Do the (birth) mother/father or siblings wear corrective lenses? Since what age? For what usage?_____

_____

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Sits too close to TV (or *wants* to but is not permitted)				
Squints to see chalkboard or other distance viewing				
Complains of blurred vision at near or far (circle)				
Red, sore, itching, or burning eyes (circle)				
Rubs eyes, blinks excessively (circle)				
Frontal headaches				
Light sensitive (or always wants to wear a cap with visor)				

TRACKING AND HAND-EYE COORDINATION

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Poor eye contact				
Head turns when reading across the page				
Depends on finger or marker to keep place in reading				
Frequent loss of place when reading				
Omits, inserts, or re-reads letters, words, sentences				
Difficulty with hand-eye sports; seldom plays with small balls				
Difficulty with catching and/or hitting in baseball/T-ball				

FOCUSING AND EYE TEAMING

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Double vision – fleeting or prolonged				
Eye turns in or out (or complains of a pulling sensation)				
Tilts head, closes or covers one eye while reading				
Headaches, dizziness, nausea with reading or riding in car				
Poor depth perception (apparent or reported)				
Blurred distance vision after near focusing				
Words blur, run together, or "jump off the page"				
Avoids reading / gets fatigued or irritable while reading				
Slow reader				
Poor reading comprehension (unless content is simple)				
Holds books too close				
Slow copying from chalkboard (other writing is quicker)				
Makes errors while copying from chalkboard				

ATTENTION AND CENTRAL – PERIPHERAL INTEGRATION

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Excessive distractibility				
Short attention span				
Excessive daydreaming				
Can concentrate only when alone and / or in silence				
Becomes overly concentrated – unresponsive to interruptions or requests				
Difficulty shifting attention from task to task / idea to idea				
Starts many activities but finishes few				
Disorganized – forgets to bring homework, lunch box, coat to or from school				
More often impulsive, imprecise and fast				
More often precise or slow				

READING: PHONICS AND SIGHT WORDS; COMPREHENSION AND MEMORY

Has your child been taught in the phonics method (sound blending and syllable analysis)? _____

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#
Avoids reading or says it is "boring"				
Becomes very frustrated, irritable, or tired while reading (after_____ minutes)				
Has difficulty sounding out new words				
Has particular difficulty with vowel sounds				
Confuses similar-looking words / words with similar beginnings / guesses using just first letter(s)				
Fails to recognize newly learned words soon thereafter				
Relies on sounding out even familiar words				
Reads aloud without appropriate inflection				
Poor memory or comprehension of what she / he reads				

OTHER SKILLS / CHALLENGES YOU WOULD LIKE US TO KNOW ABOUT

0 = Not at all 1 = Sometimes 2 = Very true # = Used to	0	1	2	#