PARENTS' QUESTIONNAIRE

GENERAL INFORMATION

Child's name_________________________Nickname________________Date of birth__________

Parents' names____
Parents' occupations: Mother_________________________ Father________________________

Address ____
____
Phone ___________________________________ Email__________________________________

REASON FOR EVALUATION

____
____
____

VISUAL HISTORY

Please describe any previous visual problems and treatment (including glasses, contact lenses, patching, medication, surgery, or vision therapy).____
____
____
How long ago was the child's last eye exam?_____________ Where? _________________________

EDUCATIONAL HISTORY

School____Grade_________
Teacher(s)____

Is your child receiving any tutoring, extra help, or special classes in school? Yes______No______
If yes, please describe.____
____

Have any evaluations been completed in school or privately? (IEP, psycho-educational, speech-language, occupational therapy, neruological, medical) Yes______No______
If yes, please describe.____
____

Please check if your child has difficulties in any of the following areas:

_______reading
_______copying from the board
_______handwriting
________math
________behavior
________attention span

Do you feel your child is performing up to his/her potential in school? Yes______No______
Does your child enjoy reading for pleasure? Yes______No______

Please continue on reverse.

DEVELOPMENTAL HISTORY

Were there any complications with pregnancy or birth? Yes_____No______ If yes, please describe.
____
Was your child born prematurely? Yes______No______ If yes, how soon?___________________
Child's birth weight_____________

When did your child begin walking unassisted? early_______ on time______ delayed ______
When did your child begin to say 2 to 3 word phrases? __________________
Any speech problems now or previously? Yes_____No______
Any problems with fine motor coordination? Yes_____ No_______
Is your child clumsy or does your child have difficulty with sports? Yes_______ No_______

MEDICAL HISTORY

Has your child had any severe childhood illnesses, hospitalizations, injuries, or physical impairments?
Yes_____ No______ If yes, please describe. ____
Has your child had frequent ear infections? Yes_____ No_____ If yes, please describe any treatments.
____
Any current health problems? Yes_____ No_______ If yes, please describe. ___________________
Please list any current medications____
Any significant allergies? Yes_____ No______ If yes, please describe. _______________________
When was your child's last physical examination? ____

FAMILY HISTORY

Does anyone in the family have any of the following?

	Relationship to Child
___strabismus (crossed eyes)	_________________
___amblyopia (lazy eye)	_________________
___high nearsightedness or farsightedness	_________________
___learning or reading problems	_________________
___blindness	_________________
___eye disease (please list)	_________________

____

ADDITIONAL COMMENTS OR CONCERNS

____
____
____
____
____
____

Please also complete the Case History Supplement for School-Age Children, a separate sheet.
Thank you.