Accent Eye Care
and Sports Vision Therapy

Parent Questionnaire

Child's Name: _____ Date Of Birth: _____
Parents' Name: _____
Occupations: Mother:_____Father: _____
Name of School: _____ Grade: _____
Teacher(s): _____

Entering Complaint / Major Concern

1. In your own words, please state briefly your main concern and the main problem your child is having:

_____

2. What has occurred that has led you to request a visual examination for your child? _____

_____

3. Who first noted the visual difficulties? _____ When? _____

4. Whose idea was it that you come in for an evaluation? (teacher, school nurse, etc)? _____

_____

Visual History:

1. Has there been previous visual care? **YES / NO**
   Please describe in detail (include any information about glasses, patching, vision therapy, medication or surgery). _____

2. Does your child report or have you noticed any of the following? (Circle one)

Yes	No	
Yes	No	a. Skips and rereads words and/or letters.
Yes	No	b. Complains of blurred vision during reading or writing.
Yes	No	c. Complains of headaches associated with visual tasks.
Yes	No	d. Complains of print "running together" or "jumping around".
Yes	No	e. Reports sensation of eyes 'not working together".
Yes	No	f. One eye turns in or out, up or down at anytime.
Yes	No	g. Experiences unusual fatigue after visual concentration.
Yes	No	h. Reports pain around or in the eyes at anytime.
Yes	No	i. Reddened eyes or lids.
Yes	No	j. Excessive tearing of eyes or rubs eyes frequently.
Yes	No	k. Blinks excessively.
Yes	No	l. Frowns, scowls, or squints with visual tasks.
Yes	No	m. Tilts or turns head while reading.
Yes	No	n. Closes or covers one eye in bright light or during visual tasks.
Yes	No	o. Moves head forward or backward while looking at a distance object.
Yes	No	p. Avoids close work.
Yes	No	q. Holds book too close while reading.
Yes	No	r. Reversals when reading (was-saw, on- no) or writing (b for d, p for q).
Yes	No	s. Uses finger as a marker when reading.
Yes	No	t. Transposition of letters or numbers (21 for 12).
Yes	No	u. Poor printing or handwriting.
Yes	No	v. Difficulty in copying from blackboard to paper.
Yes	No	w. Double vision.

Developmental History

1. Were there any complications with pregnancy or at birth? **YES / NO**
   If yes, please explain: _____
   _____
2. Was the child born premature? **YES / NO** If yes, what was the length of the pregnancy?_____
3. Child's birth weight? _____
4. Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy? **YES / NO**
   If yes, please explain: _____
5. At what age did your child crawl on all fours? _____
6. At what age could your child pull himself / herself up to chairs and tables? _____
7. At what age did your child walk? _____
8. At what age did your child first make speech sounds? _____ When and what were his / her first words? _____
   When were his / her first phrases? _____ Sentences? _____
9. Was speech clear? **YES / NO** Could others besides the family understands your child's early speech? **Y / N**
10. Is speech adequate now? _____
11. Can your child dress himself / herself? **YES / NO** Button clothes? **YES / NO** Tie bows? **YES / NO** Zip zippers? **YES / NO** Lace shoes? **YES / NO** Could the child do these before entering school? _____
12. Did the child have any early behavioral problems (temper tantrums, self-destructive behavior, difficulty sleeping, etc.)? **YES / NO**
    If yes, please explain: _____
    _____

General Health and Behavior

1. Have there been any severe childhood illnesses, high fiver, injuries, or physical impairment? **YES / NO**
   If yes, please explain: _____
   _____
2. Has the child had any ear infections? **YES / NO**
   If yes, please indicate how often and whether treatment was received: _____
3. Does the child have any allergies to food, or environmental allergies? **YES / NO**
   If yes, please indicate to what and any treatments that the child is receiving: _____

General Health and Behavior (continued)

4. Has your child ever had a neurological evaluation? **YES / NO**
   If yes, please indicate the results_____

5. Does your child have ANY history of epilepsy or seizures? **YES / NO** _____

6. What medication (such as penicillin or sulpha drugs) has been given and for what? _____

7. Has your child ever had a reaction to a medication? **YES / NO**
   If yes, please describe _____

8. Is your child currently taking medication(s) **YES / NO** If yes, please list medication and purpose :

	Medication	**Purpose**
1		
2		
3		
4		
5		

9. Has your child ever had a speech and language evaluation and/or therapy? **YES / NO**
   If yes, please indicate when and the results: _____
   _____

10. Does your child have frequent periods of extreme fatigue? **YES / NO**
    If yes, when? _____

11. Does fatigue result in sluggishness, excitability, or irritability? **YES / NO** _____

12. Does your child exhibit any tensional behavior such as nail biting, eye blinking or rubbing, tantrums, tongue chewing or lip biting, etc? **YES / NO**
    If yes, when? _____

13. Is your child good with his / her hands (for present age)? **YES / NO** Is block play good? **YES / NO**

14. Do building sets, puzzles, coloring and cutting hold attention? **YES / NO** _____

15. Does your family read a lot? **YES / NO**

16. Is there a family history of significant reading, writing, or spelling difficulties? **YES / NO**
    If yes, who?_____

17. Is there a family history of hyperactivity, attention problems, or speech difficulties? **YES / NO**
    If yes, who?_____

18. Does your child like to participate in sport activities? **YES / NO**

19. What are your child's special interests? _____

Educational Information

1. At what age did your child begin nursery school? _____ Kindergarten? _____ First Grade? _____

2. Has your child ever repeated a grade? **YES / NO** If yes, which one(s)? _____

3. Has your child had any evaluations (psychological, special education, etc.) at school? **YES / NO**
   If yes, indicate when and the results: _____
   _____

4. Does your child receive any special services from the school (speech and language, reading remediation, etc.)?
   YES / NO. If yes, indicate type and how often: _____

5. Is your child in a specialized classroom setting (self-contained, resource, etc.)? **YES / NO**
   If yes, please indicate which type:_____

6. How is your child getting along in school?_____
   In your opinion, what is his / her best subject? _____
   Easiest subject? _____ Hardest Subject? _____
   If there is difficulty at school, what do you think is the reason?_____
   _____

7. What does your child report about school, or school work? _____

8. Has the teacher reported anything about your child's school work?_____

9. Please indicate **Yes / No** for the following: (Circle one)

Yes	No	Does your child like school?
Yes	No	Does your child like his / her teacher?
Yes	No	Is the school satisfied with the child's performance?
Yes	No	Are you satisfied with the child's school performance?
Yes	No	Does your child attend school on a regular basis?
Yes	No	Is his / her school performance up to potential?
Yes	No	Is the child attending the grade level expected for his / her age?
Yes	No	Does your child read well as others in the same grade?
Yes	No	Or as well as brother or sisters? (if any)

Thank you for carefully completing this questionnaire.

Would you like a report? **Yes** **No** To Whom?

Please sign your name, giving Accent Eye Care your authorization to send reports to the following:

Name: _____

Address: _____ City: _____ Zip: _____

Name: _____

Address: _____ City: _____ Zip: _____

Name: _____

Address: _____ City: _____ Zip: _____

I give Aleta B. Gong OD, permission to release information to the above people:

Signature: _____ **Date:** _____