Accent Eye Care
and Sports Vision Therapy

Parent VT Questionnaire

Child's Name _____ Date Of Birth _____
Parents' Name _____
Occupations: Mother _____ Father _____
Name of School _____ Grade _____
Teacher(s) _____
Referred by _____ Referral Phone _____
Referral Address _____

Entering Complaint / Major Concern

1. 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	a. Skipping or rereading words/letters or losing place.
Yes	No	b. Blurred vision during reading or writing.
Yes	No	c. Headaches associated with visual tasks.
Yes	No	d. Complications with print "running together" or "jumping around".
Yes	No	e. Sensation of eyes '"not working together".
Yes	No	f. One eye turns in or out, up or down at anytime.
Yes	No	g. Unusual fatigue after visual concentration.
Yes	No	h. Pain or soreness 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. Excessive blinking.
Yes	No	l. Frowning, scowling, or squinting with visual tasks.
Yes	No	m. Tilting or turning head while reading.
Yes	No	n. Closing or covering one eye in bright light or during visual tasks.
Yes	No	o. Moving head forward or backward while looking at a distance object.
Yes	No	p. Loss of concentration or uncomfortable when reading or doing close work.
Yes	No	q. Holding a book too close when reading.
Yes	No	r. Reversals when reading (was-saw, on-no) or writing (b-d, p-q).*
Yes	No	s. Using a 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 a whiteboard or screen to paper.*
Yes	No	w. Double vision.
Yes	No	x. Reading slowly or trouble remembering what was read.*

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Visual History continued

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

Yes	No	1. Confuses similar words.*
Yes	No	2. Fails to recognize same word in next sentence.*
Yes	No	3. Confuses minor likenesses and differences.*
Yes	No	4. Difficulty following verbal instructions.*
Yes	No	5. Difficulty completing assignment in time allotted.*
Yes	No	6. Short attention span: distractible.*
Yes	No	7. Says words aloud or moves lips as reads.*
Yes	No	8. Poor eye-hand coordination.*
Yes	No	9. Repeatedly confuses right left directions.*
Yes	No	10. Poor recall of visually-presented tasks.*

* May indicate a Visual Information Processing Problem

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. Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy? **YES / NO**
If yes, please explain: _____

4. Were there any developmental delays? **YES / NO** If yes, please explain: _____

_____

_____

5. Were there 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 fever, injuries, physical impairment, or ear infections?
YES / NO If yes, please explain: _____

_____

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

_____

3. Does your child have ANY history of epilepsy or seizures? **YES / NO** If yes, please indicate the results:

_____

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

_____

_____

General Health and Behavior (continued)

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

	Medication	Purpose
1		
2		
3		
4		
5		

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

_____

_____

7. Does your 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: _____

_____

8. Does your child have frequent periods of extreme fatigue (sluggishness, excitability, irritability) or tensional behavior (nail/tongue/lip biting, eye blinking/rubbing, tantrums)? **YES / NO** If yes, please describe:

_____

9. Is there a family history of: Significant reading, writing, or spelling difficulties? **YES / NO**
Hyperactivity, attention problems, or speech difficulties? **YES / NO**

If yes, who?_____

10. What are your child's special interests (sports, hobbies, etc.)?

_____

_____

Educational Information

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

2. Has your child ever:
Had any evaluations (psychological, special education, etc.) **YES / NO**
Receive any special services from school (speech and language, reading remediation, etc.)? **YES / NO**
Been in a specialized classroom setting (self-contained, resource, etc.)? **YES / NO**
If yes, please explain: _____

_____

3. In your opinion, what is your child's best subject? _____
hardest subject? _____

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4. If there is difficulty at school, what do you think is the reason?_____

_____

_____

5. 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)

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

_____

_____

_____

Thank you for carefully completing this questionnaire.
Would you like a report? _____ To Whom? Please sign at the bottom, giving Accent Eye Care your authorization to send reports to the following:

Name: _____Phone:_____

Address: _____City: _____ Zip: _____

Name: _____Phone:_____

Address: _____City: _____ Zip: _____

Name: _____Phone:_____

Address: _____City: _____ Zip: _____

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

Signature: _____ **Date:** _____

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