the eyeclinic
Doctors + Vision Therapy

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Patient History Questionnaire- Child (5-18 years)

Please fill out the questionnaire carefully and return it to the office 1 week <u>prior</u> to your appointment. The time spent answering the questions will allow the doctor to better plan the assessment.

Child's Name: _____ Birth date: _____

School: _____ Teacher: _____
Grade: _____ Parents' Names: _____
Home Address;_____
Home Phone;_____ Best Phone # to Call:_____
Would you prefer email correspondence? If so, email address _____
Who Referred you to The Eye Clinic?_____
Person completing the Questionnaire_____
Date Form Completed:_____

If you have received reports from other professionals such as psychologists, teachers, audiologists, speech therapists, occupational therapists, etc., it would be very helpful for you to send these reports to Dr. Matyas along with the questionnaire.

NOTES

- **The assessment is approximately 1 hour long**
- **Make sure your child is well rested on the day of the appointment**
- **If (s)he wears glass for reading, (s)he will need them for the testing**
- **Bring your child's health card**
- **Payment is by Visa, Mastercard or Debit**

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

We request a minimum of 48 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status. Testing is one-on- one with the optometrist.

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this vision skills evaluation?

_____
_____
_____

How long have these concerns been observed?_____ How has the child handled the difficulty? _____

What goal(s) do you hope to accomplish from the visual perceptual evaluation?

_____
_____

In your opinion, is vision impacting academic performance? _____
Has your child expressed concerns regarding vision?_____
Last Vision evaluation (year)
_____Doctor:_____City:_____
Does your child currently wear glasses?_____
Reason?_____ Year first prescribed: _____
Has your child previously worn glasses, but not at present? Reason for discontinued wear?
_____
_____
Does your child currently wear contact lenses? _____
Has your child previously received vision therapy?_____
Reason:_____ Doctor: _____

If your child has an eye turn, please fill out the following section:

At what age did you notice the eye first turn?_____
Has your child had eye surgery?_____
Reason:_____Doctor:_____
If yes, give details such as age surgery was performed, number of operations, eye operated on and results_____
_____
_____
Has your child had any treatment with a patch? _____ . If yes, please describe the patching schedule_____
_____

1- always 2- a lot 3- sometimes

Put a check on the line if your child has reported, or you have observed the following:

___ skips, inserts or rereads words
____ loses place while reading
omits small words when reading
___ mistakes words with similar beginnings and endings
___ uses finger as a marker
____moves head when reading
____ head close to page when reading
___ reads slowly

____reduced efficiency /productivity
____headaches during/after reading
blurred distance vision
____blurred reading vision
___ eyes hurt
___ eyes tire
___ poor reading comprehension
____comprehension decreases with time
____frequent blinking during reading
____frowns, scowls or squints to see
____avoids/ dislikes near tasks ie. reading
___ fatigues easily during visual tasks
____rubs eyes during/after visual activity
___ inaccurate/ inconsistent visual attention
___ vision worse at end of day
___ falls asleep when reading
___ double vision
____words move around the page
____tilts head during desk work
____closes or covers one eye
___ one eye turns in, out, up or down

___difficulty copying from board
___confuses similar words
fails to recognize same word on next page

___difficulty following verbal instructions
___ says **words aloud or moves lips as reads**
___ short attention span/loses interest
poor printing or handwriting
responds better verbally than by writing
___ writes neatly but slowly
___ reverses letters, words or numbers
___confuses left and right
___tends to knock things over on desk/table
___ poor recall of visually presented tasks
___ school performance not up to potential
___ nausea associated with visual tasks
___ motion sickness/car sickness
___ easily frustrated
___ light sensitivity
___ variable school performance
___ difficulty aligning number columns
___ seems to know material, but does poorly on tests
___ bumps into people/objects
___ forgetful, poor memory
___ behaviour problems
___ poor ability to organize work
___ indistinct speech

DEVELOPMENTAL HISTORY

Full Term Pregnancy?____ Yes_____No
Normal Birth?___Yes____No
If complications, please explain:_____
_____

Motor Development

Did your child crawl (stomach on floor) ? ____Yes_____No At what age?_____
Did your child creep (on all fours)? ___Yes_____No. At what age?_____
At what age did your child start to walk?_____
Did your child have difficulty learning to throw or catch a ball ? ___Yes___No
Did your child have difficulty learning to cut with scissors? ___ Yes___No
Did your child have difficulty learning to tie shoelaces? ___ Yes___No
Did your child have difficulty learning to ride a bicycle? ___ Yes___No

SCHOOL HISTORY

Rate your child's progress in the following subjects:

1 – Below Average 2 – Average 3 – Advanced

_____ Reading _____Writing _____ Spelling _____ Arithmetic

Child's Current Reading Level: Grade _____

Does your child like school? ___Yes ___ No
Specifically describe any school difficulties_____
_____
_____
Do you feel your child is reaching his/her potential?-____Yes_____No
Does the teacher feel you child is achieving his/her potential?_____Yes_____No
Does your child have an IEP at school? ____. If so, describe the type of accommodations
_____
_____
Does your child like to read?___Yes____No Voluntarily?_____Yes_____No

Does your child need to spend a lot of time/effort to maintain this level of performance?
____Yes _____No

How much time on average does your child spend on homework each day?_____
To what extent do you assist your child with homework?_____

MEDICAL HISTORY

Is your child generally healthy? _____ Yes _____ No
Has there been any severe childhood illness, high fever, injury or physical impairment?
_____ Yes _____ No . |If yes, please explain_____
_____

Are there any chronic problems like ear infections, asthma, hay fever allergies? If yes, please list: _____

Name of Physician or Pediatrician:_____ City_____

Is your child currently taking any medications? _____ Yes _____ No
Please list medication(s) and their purposes: _____

Has your child previously taken medication for hyperactivity? _____ Yes _____ No

Has your child received a hearing test? _____ Yes_____ No
Date of test: _____. Name of Clinic or Dr. _____

Has a hearing or speech deficiency been previously diagnosed? _____ Yes _____No
If yes, please explain: _____

Is there history of concussion or whiplash?___Yes___ No. If yes, please explain_____
_____
_____

Has your child received any of the following special testing with respect to the present learning problem?

	Yes or No	When	By Whom	Results
Occupational Therapy	_____	_____	_____	_____
Psychological	_____	_____	_____	_____
Neurological	_____	_____	_____	_____
Other:_____		_____	_____	_____

Has your child had any special tutoring or therapy? If so, fill out the following:

Type of Therapy:	Dates:	Results:
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEISURE TIME ACTIVITIES/ TELEVISION AND COMPUTER VIEWING

How much time per day does your child spend watching TV?_____Viewing Distance?_____
How much time per day does your child spend on the computer/video games?_____
What extracurricular activities does your child enjoy?_____
Are there any activities your child would like to participate in, but doesn't?___ If so, please explain_____
_____

Additional comments about your child which you feel may be important/ helpful in our treatment of your child:

_____

_____

_____

_____

Give a brief description of your child as a person:

_____

_____

_____

March 2017