all ages vision care
learning-related vision specialists

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CHILDRENS VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided or fax to 704-405-1225. THANK YOU.

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION
Did you find our office on the internet? Yes ☐ No ☐
Were you referred to our office? Yes ☐ No ☐
If yes whom may we thank for this referral? _____ Phone: _____
Address: _____
Child's Full Name: _____
Birth Date: _____ Age: _____years _____months Male _____ Female _____
Name and address of school: _____
Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____
Is your child especially afraid of doctors? _____
Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes ☐ No ☐

Please list the names and birth dates of your family:

NAME
Father/Caretaker _____ Birth Date _____
Mother/Caretaker _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____
Sibling _____ Birth Date _____

RESPONSIBLE PERSON INFORMATION
Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Email Address: _____
Father/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Mother/Caretaker's Occupation: _____ Business Phone: _____
Business Address: _____ City: _____ Zip: _____
Father's Mobile Phone: _____ Mother's Mobile Phone: _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the insurance carrier? _____
Name of Insured: _____
Policy/ID #: _____ Group #: _____

MEDICAL HISTORY
Pediatrician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Child's current state of health: _____
_____
Medications currently using and dosage (including vitamins, supplements, and eye medications): _____
_____
For what condition(s)? _____
_____

Immunizations child has received (necessary for 10 years and under):

Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: _____

List illnesses/infections, bad falls/head trauma, high fevers, ear etc.:

Age	Severe	Mild	Complications

List any general surgeries and eye surgeries:

Surgery	Age	Duration of Stay	Treatment

Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
Has a psychological or educational evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
Has a speech and language evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

Is there any history of the following? (please check if there is a history)

	Patient	**Family**	**Who**		**Patient**	**Family**	**Who**
Lazy eye	☐	☐	_____	Blindness	☐	☐	_____
Crossed eye	☐	☐	_____	Diabetes	☐	☐	_____
Dyslexia	☐	☐	_____	Heart Disease	☐	☐	_____
Learning Disability	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
Stroke	☐	☐	_____	Epilepsy or Seizures	☐	☐	_____
Cancer	☐	☐	_____	Eye Disease			
High Blood Pressure	☐	☐	_____	(Glaucoma, Cataracts, Etc.)	☐	☐	_____
				Other	☐	☐	_____

If other, please explain: _____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does your child: Like sweets ☐ or crave sweets ☐
If yes, what types? _____
Is your child active? Yes ☐ No ☐
moderately? Yes ☐ No ☐
extremely? Yes ☐ No ☐
Are there periods of
very high energy? Yes ☐ No ☐
very low energy? Yes ☐ No ☐
Explain: _____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Normal birth? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
Birth weight: _____ Apgar scores @ birth: _____ After 10 minutes: _____
Were forceps used? Yes ☐ No ☐
Was there ever any reason for concern over your child's general growth or development?
Yes ☐ No ☐.
If yes, why? _____
Did your child crawl (stomach on floor)? Yes ☐ No ☐ At what age? _____
Did your child creep (on all fours)? Yes ☐ No ☐ At what age? _____
If not, describe: _____
At what age did your child walk? _____
Was child active? Yes ☐ No ☐
Speech: First words: _____ At what age: _____
Was early speech clear to others? Yes ☐ No ☐
Is speech clear now? Yes ☐ No ☐

VISUAL HISTORY

Has your child's vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they used? Yes ☐ No ☐ If yes, when? _____
If not used, why not? _____
Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation

PRESENT SITUATION

Why do you feel your child needs a visual evaluation? _____

How long has this problem/difficulty been observed? _____
Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes ☐ No ☐
If yes, what? _____

Does your child report any of the following?:	Yes	No	If yes, when?
Please ask your child			
Headaches	☐	☐	
Blurred vision / focus goes in and out	☐	☐	
Double vision	☐	☐	
Eyes hurt	☐	☐	
Eyes tired	☐	☐	
Words move around on the page	☐	☐	
Motion sickness / car sickness	☐	☐	
Dizziness	☐	☐	

List any other complaints your child makes concerning his/her vision: _____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

	Yes	No		Yes	No
Eyes frequently reddened	☐	☐	Poor reading comprehension	☐	☐
Frequent eye rubbing	☐	☐	Writes or prints poorly	☐	☐
Frequent sties	☐	☐	Writes neatly but slowly	☐	☐
Frowning	☐	☐	Does not support paper when writing	☐	☐
Bothered by light	☐	☐	Awkward or immature pencil grip	☐	☐
Frequent blinking	☐	☐	Frequent erasures	☐	☐
Closing or covering one eye	☐	☐	Tires easily	☐	☐
Difficulty seeing distant objects	☐	☐	Difficulty copying from chalkboard	☐	☐
Head close to paper when reading or writing	☐	☐	Difficulty recognizing same word on different page	☐	☐
Avoids reading	☐	☐	Poor word attack skills	☐	☐
Prefers being read to	☐	☐	Difficulty with memory	☐	☐
Tilts head when reading	☐	☐	Remembers better what hears than sees	☐	☐
Tilts head when writing	☐	☐	Responds better orally than by writing	☐	☐
Moves head when reading	☐	☐	Seems to know material, but does poorly on tests	☐	☐
Skips, rereads or omits words	☐	☐	Dislikes / avoids near tasks	☐	☐
Loses place while reading	☐	☐	Short attention span / loses interest	☐	☐
Uses finger as a marker	☐	☐	Poor large motor coordination and balance	☐	☐
Comprehension decreases over time	☐	☐	Poor fine motor coordination	☐	☐
Confuses letter or words	☐	☐	Difficulty with scissors / small hand tools	☐	☐
Reverses letter or words	☐	☐	Dislikes / avoids sports	☐	☐
Confuses right and left	☐	☐	Difficulty catching / hitting a ball	☐	☐
Vocalizes when reading silently	☐	☐			
Reads slowly	☐	☐			

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Does child watch TV? _____ How much? _____ How often? _____ Viewing distance? _____
Does your child spend time using computer/video games? Yes ☐ No ☐
If yes, how much? _____ How often? _____ Viewing distance? _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____
Please explain: _____

SCHOOL

Age at time of entrance to: Pre-school _____ Kindergarten _____ First Grade _____
Does your child like school? Yes ☐ No ☐
Specifically describe any school difficulties: _____
Has your child changed schools often? Yes ☐ No ☐
If yes, when? _____
Has a grade been repeated? Yes ☐ No ☐
If yes, which and why? _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes ☐ No ☐
Has your child had any special tutoring, therapy, and/or remedial assistance?.....Yes ☐ No ☐
If yes, when? _____
Where and from whom? _____
How long? _____
Results: _____
Does your child like to read? Yes ☐ No ☐
Voluntarily? Yes ☐ No ☐
Does your child read for pleasure? Yes ☐ No ☐
What? _____

What is your child's attitude toward reading, school, his/her teachers, other youngsters? _____

Overall schoolwork is: above average ☐ average ☐ below average ☐
WHICH SUBJECTS ARE:
Above average: _____
Average: _____
Below average: _____
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 each day on homework assignments? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to potential? Yes ☐ No ☐
Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐

GENERAL BEHAVIOR
Are there any behavior problems at school? Yes ☐ No ☐
If yes, what? _____
Are there any behavior problems at home? Yes ☐ No ☐
If yes, what? _____
What causes these problems? _____
Child's reaction to fatigue? sag ☐ irritable ☐ other ☐
Child's reaction to tension? avoidance ☐ irritable ☐ other ☐ _____
Does your child say and/or do things impulsively? Yes ☐ No ☐
Is your child in constant motion? Yes ☐ No ☐
Can your child sit still for long periods? Yes ☐ No ☐

FAMILY AND HOME
Please indicate which adult(s) he/she lives with? Mother ☐ Father ☐ Stepmother ☐
Stepfather ☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather ☐
Aunt ☐ Uncle ☐ Other Caretaker (please specify): _____
Does your child spend time with any other person, not in the home? Yes ☐ No ☐
Please explain: _____
Has your child ever been through a traumatic family situation (such as divorce, parental loss,
separation, severe parental illness)? Yes ☐ No ☐
If yes, at what age: _____
Does your child seem to have adjusted? Yes ☐ No ☐
Was counseling /therapy undertaken? Yes ☐ No ☐
If yes, is it on-going? Yes ☐ No ☐
Is family life stable at this time? Yes ☐ No ☐
If no, please explain: _____
How does your child get along with:
Parents/other caretakers? _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____
Did father or anyone in father's family have a learning problem? Yes ☐ No ☐
If yes, who? _____
Did mother or anyone in mother's family have a learning problem? Yes ☐ No ☐
If yes, who? _____

Do any, or did any, of the other children in the family have learning problems? ..... Yes ☐ No ☐
If yes, who? _____
To what extent? _____
_____
_____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of All Ages Vision Care when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Beasley and All Ages Vision Care to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature Date

_____

RELATIONSHIP TO PATIENT

I hereby give my permission to All Ages Vision Care to treat _____.

(Child's Name)

_____ _____

Parent's or Guardian's Signature Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

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

You may leave a message for us 24 hours a day, 7 days a week. We request a minimum of 24 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. Please mail this form to our office at All Ages Vision Care, Attn: Wendy Hartman, 6917 Shannon Willow Road, Suite 100, Charlotte, NC 28226-1333, or fax it to 704-405-1225.

THANK YOU.

SINCERELY,

GENIA BEASLEY, O.D., F.C.O.V.D., F. A. A. O.
BOARD CERTIFIED IN VISION THERAPY AND VISION DEVELOPMENT