

**CHILD EXAMINATION QUESTIONNAIRE FOR PARENTS**

Today's Date \_\_\_\_\_

Child's full name \_\_\_\_\_ Nickname, or likes to be called \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ years and \_\_\_\_\_ months Brothers/Sisters Age

Name of School \_\_\_\_\_ Grade \_\_\_\_\_

School Address \_\_\_\_\_ Teacher \_\_\_\_\_

\_\_\_\_\_ School Nurse \_\_\_\_\_

Brief Summary of your main concerns \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**SCHOOL HISTORY**

1. Age of entrance into kindergarten \_\_\_\_\_ first grade \_\_\_\_\_

2. Does your child like School \_\_\_\_\_

3. Easiest subject(s) \_\_\_\_\_

4. Hardest Subject(s) \_\_\_\_\_

5. Are there any school difficulties? If so, please describe them and when they began:

\_\_\_\_\_

\_\_\_\_\_

6. Has there been any remedial work? If yes, please give specifics:

\_\_\_\_\_

\_\_\_\_\_

7. Has a grade ever been repeated? \_\_\_\_\_ If so, which? \_\_\_\_\_

8. Has there ever been any psychological, educational, audiological or other testing performed? \_\_\_\_\_

If yes, please give specifics: \_\_\_\_\_

\_\_\_\_\_

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**(please turn the page over and complete the other side)**

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**GENERAL BEHAVIOR**

*Please place a check mark next to any of the following behaviors that you believe your child exhibits, and next to any problem that seems to occur often.*

High activity level	
Poor attention span	
Impulsivity	
Frustrates easily	
Doesn't listen when spoken to	
Poor memory	
More active than other children his (her) age	

**GENERAL HEALTH**

1. Any significant illnesses? \_\_\_\_\_

If yes please specify \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Is (s)he taking any medication? \_\_\_\_\_

If yes please specify \_\_\_\_\_

**Previous Vision History**

1. When was the last eye examination \_\_\_\_\_

By whom \_\_\_\_\_

2. Have glasses ever been prescribed? \_\_\_\_\_

If yes give specifics \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Does anyone in the family have any vision problems? \_\_\_\_\_

If yes specify \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signs of Eye Teaming Problems**

Covers or closes one eye when reading	
Rubs eyes	
Child complains of eyestrain	
Child complains of headaches	
Child complains of double vision	
Child complains of words moving on the page	
Inattentive	
Poor reading comprehension	
Loses place	

**Signs of Focusing Problems**

Child complains of blurred vision	
Child complains of blurred vision when looking from desk to board	
Child complains of eyestrain	
Child complains of headaches	
Rubs eyes	
Inattentive	
Poor reading comprehension	
Is tired at the end of the day	
Holds things very close	

**Signs of Tracking Problems**

Loses place often	
Must use finger or guide to keep place	
Skips lines and words often	
Poor reading comprehension	
Short attention span	

**Signs of Visual Processing Disorders**

Trouble learning left from right	
Reverses letters and numbers	
Mistakes words with similar beginnings	
Can't recognize the same word repeated on a page	
Trouble learning basic math concepts of size, magnitude	
Poor reading comprehension	
Poor recall of visually presented material	
Trouble with spelling and sight vocabulary	
Sloppy writing skills	
Trouble copying from board to book	
Erases excessively	
Can't respond orally but not in writing	
Seems to know material but does poorly on written tests	