**PARENT QUESTIONNAIRE**

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date\_\_\_\_\_\_\_\_**\_\_\_\_**Today’s Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Name and Pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Grade**\_\_\_\_\_\_\_ **Teacher**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parents' names:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupations: Parent:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Parent:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL address to receive your report of the evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**A. My child is here today because:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1.Who first noted possible visual difficulties and when did they start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. VISUAL HISTORY**

1) Is this your child's first visual examination? Yes \_\_\_\_ No\_\_\_\_

If not, when was their last examination and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Please describe any previous eye or visual problems, and treatment your child has received. (including glasses, vision therapy, patching, surgery, medication). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3) Please check any of the following that you have noticed or that your child complains about:

\_\_\_ blurred distance vision \_\_\_ blurred vision during reading

\_\_\_ double vision \_\_\_ words moving or running together

\_\_\_ closes or covers one eye during reading \_\_\_ tilts head

\_\_\_ eye turns in, out, up, down \_\_\_ frequent headaches

\_\_\_ fatigue during near visual tasks \_\_\_ eye strain

\_\_\_ squints or blinks excessively \_\_\_ red or teary eyes

\_\_\_ holds book or paper too close \_\_\_ avoids close work

\_\_\_ loss of place when reading \_\_\_ skips or rereads lines

\_\_\_ uses finger or underliner to read \_\_\_ frequent reversals

\_\_\_ poor eye-hand coordination \_\_\_ poor depth perception

\_\_\_ rubs eyes frequently during reading \_\_\_ dizziness, headaches or eyestrain during 3D movies

\_\_\_ difficulty with similarities and differences in letters, pictures, or words

**C. EDUCATIONAL HISTORY**

1)Has your child repeated any grades? Yes \_\_\_\_ No \_\_\_\_ If yes, which one? \_\_\_\_

2)Is your child receiving any tutoring, extra help or special classes in school? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3) Have there been any evaluations done at school or by school recommendation? (psychological, learning, speech/language, occupational therapy, neurological, medical) Yes \_\_\_\_ No \_\_\_\_ If yes, please list tests and briefly describe the results.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Please check if your child has difficulties in any of the following areas:

**\_\_\_** reading \_\_\_ handwriting \_\_\_ math

\_\_\_ spelling \_\_\_ copying from the board \_\_\_ attention span

\_\_\_ behavior or motivation \_\_\_ homework takes longer than it should

5) Please check if any of the following aspects of reading are difficult or are behaviors you have noted during reading:

\_\_\_ comprehension \_\_\_ word recognition \_\_\_ phonics

\_\_\_ slow reading \_\_\_ loss of place \_\_\_ fatigue

\_\_\_ uses finger \_\_\_ avoidance \_\_\_ omits small words

\_\_\_ headaches or eyestrain \_\_\_ comprehension declines the longer they read

(OVER)

 6) Do you feel your child is performing up to their potential in school? Yes \_\_\_\_ No \_\_\_\_

 7) Does your child enjoy reading for pleasure? Yes \_\_\_\_ No \_\_\_\_

 8) Does your child play any musical instruments? Yes \_\_\_ No \_\_\_ Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9) Does your child play any organized sports? Yes \_\_\_ No \_\_\_ Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D. DEVELOPMENTAL HISTORY**

 1)Were there any complications with pregnancy or during birth? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2) Was your child born prematurely? Yes \_\_\_\_ No \_\_\_\_ If yes, how premature? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3) Child's birth weight\_\_\_\_\_\_\_\_ Apgar Score\_\_\_\_\_\_\_\_\_\_

4)At what age did your child begin walking unassisted? early \_\_\_\_ on time \_\_\_\_ delayed or late \_\_\_\_

 5) At what age did your child begin to say 2 to 3 word phrases? \_\_\_\_\_\_\_\_\_

6)Any speech problems now or in the past? Yes \_\_\_\_ No \_\_\_\_

 7)Any problems with fine motor coordination? Yes \_\_\_\_ No \_\_\_\_

 8) Is your child clumsy or have difficulty with activities requiring good balance? Yes \_\_\_\_ No \_\_\_\_

 9) Does your child enjoy and participate in activities such as drawing, coloring, puzzles, block play, etc.? Yes \_\_\_\_ No \_\_\_\_

**E. MEDICAL HISTORY**

 1) Has your child had any severe childhood illnesses, hospitalizations, injuries, or physical impairment? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2) Has your child had frequent ear infections? Yes \_\_\_\_ No \_\_\_\_ If yes, what treatments have they undergone?\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3) Any current health problems? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 4) Is your child taking any medications? Yes \_\_\_\_ No \_\_\_\_ If yes, list drugs and doctor that has prescribed them:

 5) Who is your child's primary doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6) Any significant allergies? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**F. FAMILY HISTORY**

 1) Does anyone in the family have any of the following?

 Relationship to child

\_\_\_ strabismus (crossed eyes) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ amblyopia (lazy eye) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ high nearsightedness, farsightedness, or astigmatism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ learning or reading problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ blindness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ eye disease (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list the names, fax number, or email address for any doctors or therapists who you would like to receive a report of today’s evaluation.**

**1) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**