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InDepth Vision
VISION THERAPY AND REHABILITATION

CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire and return it to our office at least 48 hours prior to your appointment. Thank you.

Patient's full name: _____ Date of Birth: _____
Address: _____ Phone number: _____
_____ Email: _____
Parent/Caregiver name(s): _____
Health Card Number: _____ Version Code: _____ Expiry: _____
Credit Card Number: _____ Expiry: _____ Security Code: _____
Name on Credit Card: _____ Billing Address: _____
Were you referred to our clinic? ☐ Yes ☐ No
If yes, whom may we thank for this referral? _____

MEDICAL HISTORY

Family Doctor: _____ Family Doctor Phone Number: _____
Allergies: _____
Medical conditions: _____
_____
Medications (incl. vitamins/supplements): _____
_____
Do any eye diseases run in the family? _____
_____

VISUAL HISTORY

Main reason for having an examination today? _____
_____
Date of last eye exam: _____ Optometrist: _____
Has your child been diagnosed with an eye disease? _____
_____
Please describe any previous eye or vision problems and treatment your child has received (including glasses, vision therapy, patching, surgery, medications, etc.): _____
_____

Does your child wear glasses? ☐ Yes ☐ No ☐ N/A

When did your child begin wearing glasses? _____

Do you observe, or does your child report any of the following: (Please check all that apply)

- ☐ Headaches
- ☐ Blurred Vision (near)
- ☐ Blurred Vision (far)
- ☐ Tilts head
- ☐ Light sensitivity
- ☐ Difficulties with memory
- ☐ Double Vision
- ☐ Eyes hurt or tired
- ☐ Squinting
- ☐ Motion/car sickness
- ☐ Focus goes in and out
- ☐ Loses attention easily
- ☐ Crossed or wandering eye
- ☐ Difficulty tracking an object
- ☐ Closes or covers one eye
- ☐ Burning, itching or tearing
- ☐ Nausea with visual tasks

EDUCATIONAL HISTORY

Current school: _____ Grade: _____

Is your child receiving any tutoring, extra help or special classes? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been diagnosed with a learning disability? ☐ Yes ☐ No

If yes, please describe: _____

How much time each day, on average, does your child spend on homework/assignments? _____

To what extent do you assist your child with his/her homework/assignments? _____

Do you feel your child is achieving up to his/her potential? ☐ Yes ☐ No

Does the teacher feel your child is achieving up to his/her potential? ☐ Yes ☐ No

Academic concerns:

- ☐ Avoids reading
- ☐ Poor, inefficient reading
- ☐ Loses place while reading
- ☐ Poor reading comprehension
- ☐ Vocalizes when reading
- ☐ Uses finger to track along line when reading
- ☐ Holds book really close
- ☐ Skips, rereads or omits words/lines
- ☐ Words moving/running together
- ☐ Confuses left and right
- ☐ Difficulty copying from the board
- ☐ Poor spelling
- ☐ Poor handwriting
- ☐ Frequent letter, number or word reversals
- ☐ Math difficulty (facts/concepts)

Current academic levels:

	Above Grade	On Grade	Below Grade	Special Help
Reading	☐	☐	☐	☐
Reading Comprehension	☐	☐	☐	☐
Spelling	☐	☐	☐	☐
Math	☐	☐	☐	☐
Handwriting	☐	☐	☐	☐

DEVELOPMENTAL HISTORY

Full-term pregnancy? ☐ Yes ☐ No If no, how premature?

Were there any complications during pregnancy and/or delivery? ☐ Yes ☐ No

If yes, please explain:

Birth weight: Apgar score @ 1 min: Apgar score @ 5 min:

When did you child begin crawling?

Was it a normal crawl? ☐ Yes ☐ No

If no, please describe the crawl (i.e. bum scoot, one legged crawl, etc.)?

When did your child begin walking unassisted?

Was your child delayed in meeting any of their developmental milestones? ☐ Yes ☐ No

If yes, please explain:

Any speech problems? ☐ Yes ☐ No Any problems with fine motor coordination? ☐ Yes ☐ No

Is your child clumsy? ☐ Yes ☐ No

Any other pertinent information?

FURTHER INFORMATION

Is there anything else you would like to tell us?

PLEASE BRING YOUR CURRENT GLASSES AND SUNGLASSES TO YOUR EXAM