



# ARLINGTON VISION THERAPY

Improving Vision, Improving Life

5906 Cemetery Road, Arlington, WA 98223

(360) 474-9620

Please fill out this questionnaire carefully and return to our office prior to your appointment. *THANK YOU.*

## ▶ CHILDREN'S VISION QUESTIONNAIRE

▶ Patient's Name:

▶ Appointment Date:

Address:

City:

State:

Parent/ Guardian:

Phone:

Email (optional):

Patient's School:

Grade or Occupation:

Referred By:

Write a brief description of your immediate concerns related to your child's vision:

Please write a brief description of your child as a person:

# CHILDREN'S VISION QUESTIONNAIRE

Please answer to the best of your ability:

**General Behavior (circle Y for yes or N for no)**

**Does your child:**

- have irregular sleep patterns?      Y N
- crave sweets?                              Y N
- fatigue easily?                              Y N
- become easily frustrated?              Y N
- avoid difficult activities?              Y N
- seem to be in constant motion?      Y N
- have difficulty following directions? Y N
- struggle to express him/herself?    Y N

**Please circle the answer:**

My child spends the majority of his/her time with:

Parent    Sibling(s)    Daycare setting    Foster care

Other: \_\_\_\_\_

In a group setting, my child is mostly:

Shy    Timid    Easygoing    Assertive

\*\*\*\*\*

**Visual History      Last Exam Date:**

By whom:

What were the results / recommendations (**circle**):

None    Glasses    Contacts    Patching

Other: \_\_\_\_\_

\*\*\*\*\*

**Behavioral Symptoms (circle all applicable)**

**Does your child report any of the following:**

- Headaches    Blurred Vision    Poor focusing
- Double vision    Eyes hurt            Eyes tired
- Words move around on page    Motion Sickness
- Dizziness            When: \_\_\_\_\_

**Leisure Activity**

**Media:**

TV    Computer    XBOX    Other: \_\_\_\_\_

Estimated length of time in a day spent: \_\_\_\_\_

Viewing distance is usually 2 feet or less      Y N

**Literature:    Does your child:**

- skip lines when reading?      Y N
- reverse letters or words?      Y N
- prefer you to read?              Y N
- avoid reading?                      Y N

**Sports:    My child has difficulty:**

- keeping his eye on the ball?              Y N
- judging distance and speed of objects?      Y N
- executing basic hand/eye coordination?      Y N
- avoid sports?                              Y N

**Crafts:    My child has difficulty:**

- coloring within the lines              Y N
- using scissors to cut on a line          Y N
- threading beads                          Y N
- following 2 or 3 step directions          Y N
- or avoids fine motor activities          Y N

\*\*\*\*\*

**Academic Performance: (circle one)**

**My child is:**

\_\_\_\_\_ Grade level for Reading fluency.

Below    At    Above

\_\_\_\_\_ Grade level for Reading comprehension.

Below    At    Above

**Does your child:**

struggle to finish assignments on time?    Y    N

expend a lot of effort to maintain

performance in class?    Y    N

have a current IEP program?    Y    N

\*\*\*\*\*

**Medical History:**

Date of last well check or physical: \_\_\_\_\_

Are immunizations current?    Y    N

Presence of chronic health problems like

Asthma, allergies, ear infections?    Y    N

Premature birth, Oxygen at birth?    Y    N

Current medications:    Y    N

\*\*\*\*\*

Additional Comments:

---

---

---

---

**Family History**

Please circle if there is a known patient or family history:

Diabetes    Learning disability    Amplyopia (Lazy eye)

Cross Eye    Chromosomal Imbalance    Epilepsy

Multiple Sclerosis    Glaucoma    High blood pressure

\*\*My child has other siblings in the family who have benefited from Vision Therapy.    Y    N

**Environmental Stressors:**

Please circle if there are known family stressors either current or within the last 3 years:

Separation or divorce    Sibling(s) move out of house

Debilitating Accident /Illness    New home or school

Other: \_\_\_\_\_

\*\*\*\*\*

**Past Interventions:**

IEP    Y    N

Counseling    Y    N

Therapy    Y    N

Hospitalization(s)    Y    N

\*\*\*\*\*