Children's Vision Questionnaire

Name_____ Age_____ Date _____

Pediatrician _____

Pediatrician Address & Phone# _____ Fax#_____

BINOCULAR
VISION & VISUAL EFFICIENCY HISTORY
(Please circle Y or N)

Complains of blurred vision	Y or N	Holds things very close	Y or N
Complains of blurred vision		Loses place often	Y or N
when looking near to far or far to near	Y or N	Complains of eyestrain	Y or N
Complains of headaches	Y or N	Must use finger to guide and keep place	Y or N
Rubs eyes	Y or N	Skips lines and words often	Y or N
Inattentive	Y or N	Misreads parts of words	Y or N
Avoids reading	Y or N	Covers or closes one eye when reading	Y or N
Poor reading comprehension	Y or N	Complains of double vision	Y or N
Is tired after reading	Y or N	Complains of words moving on the page	Y or N
Slow worker	Y or N	Complains or words running together	Y or N
All above negative	Y or N		

GENERAL BEHAVIOR

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

SIGNS OF VISUAL PROCESSING DISORDERS

Reverses letters and numbers	Y or N
Mistakes words with similar beginnings	Y or N
Can't recognize same word repeated on the page	Y or N
Poor recall of visually presented materials	Y or N
Trouble with spelling	Y or N
Sloppy writing skills	Y or N
Erases Excessively	Y or N
All above negative	Y or N

Does your child like school? Y or N

How are his(her) grades? Excellent, Good, Fair, Poor

Please list any academic area(s) of difficulty _____

Do you feel your child is achieving up to potential? Y or N