# LEARNING RELATED VISION DIFFICULTY ASSESSMENT QUESTIONNAIRE

**Name**_____ DOB____/____/____

**Parents Names**_____

**A. Reason for vision assessment/Major concerns:** _____

_____

_____

**Who** referred you to our practice?_____

**B. Visual History**

**Is** this your child's first vision examination? Yes / No

**If not,** when was their last examination? _____

Please list any previous **vision** treatment your child has received including glasses, vision therapy, patching, surgery or medication and under who's care. _____

_____

_____

Please tick any of the following that you or your child's teacher have noticed or that your child complains of:

___blurred distance vision
___double vision
___closes one eye when reading
___one eye turns in, out, up, down
___tires quickly during near tasks
___squints or blinks excessively
___holds book or paper very close
___loss of place when reading
___uses finger or underliner to read
___poor eye-hand coordination

___blurred vision during reading
___words moving/running together
___often tilts head
___frequent headaches
___eye strain
___red or teary eyes
___avoids close work
___skips or rereads lines
___*frequent accidents/clumsy*
___*trouble learning left from right*

___ *reverses letters/numbers*
___*mistakes similar words*
___*trouble learning basic maths*
___*poor comprehension*
___*poor memory*
___*trouble with spelling*
___*poor hand writing skills*
___*trouble copying from board*
___*erases excessively*
___*responds better orally*

**C. Educational History**

Has your child repeated any years at school? **Yes / No**

If so, which one?_____

Is your child receiving any extra help at school or in any special classes?

Please describe_____

**Please circle** any relevant evaluations completed and provide contact details:

Psychological Speech/Language Occupational Therapy Neurology Medical

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**Please tick** if your child is experiencing difficulties in any of the following areas

___ reading ___ handwriting ___ word recognition ___ behaviour
___ spelling ___ copying from the board ___ attention span ___ sports
___ maths ___ avoidance ___phonics/sounding out words
___ processing or reading speed/completing assignments in time
___ good comprehension when I read to my child, but difficulty when reading alone
___ not performing to potential in the classroom

**D. Developmental History**

Please list any complications during: Pregnancy Delivery Post-natal

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**Please circle** approximate age these developmental milestones were made:

| | | | | |
|---|---|---|---|---|
| Crawling | 6-9 months | 9-12 months | >12 months | Limited crawling |
| Walking | <12 months | 12-18 months | 18-24 months | >2 years |
| First Words | < 12 months | 12-18 months | 18-24 months | >2 years |
| Sentences | <2 years | 2-3 years | 3-4 years | >4 years |
| Riding a two wheeler | <4 years | 4-5 years | 5-6 years | >6 years |

**E. Medical History**

Have there been any serious or recurrent childhood illnesses, injuries or physical impairment?

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Please describe any treatment for above_____

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Please list any current health problems and medications_____

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Please List any known allergies _____

**F. Family History.**

Does anyone in the family have any of the following?

___ squint (crossed eyes) ___ lazy eye (amblyopia)
___ short sightedness ___Mother? Age of onset___
___Father? Age of onset___
___ far sightedness or astigmatism
___ learning or reading problems
___ eye disease. **Please List** _____