

Date: _____ Child's Name: _____

Name of School: _____ Grade: _____ Teacher's Name: _____

1.) What is the reason for the vision examination? _____

2.) How long has the difficulty been noticed? _____

3.) Does the child like school? Yes No

4.) Have there been any school difficulties? Yes No

If Yes, explain: _____

5.) Is school work better than average average below average

6.) What were the grades on the last report card in the following?

Reading _____ Writing _____

Spelling _____ Mathematics _____

Developmental and Behavioral History

Full term pregnancy? Yes No

Normal Birth? Yes No

If No, complications before, during or following delivery?

Was there anything unusual about the crawling or early motor development?

At what age did your child first talk? _____

Was speech clear? Yes No

First walked alone at what age? _____

Can most children his/her age throw or catch a ball better? Yes No

Hand preference was clearly indicated at what age? _____

Was handedness ever changed? Yes No

Reading/Writing and other desk tasks

For Clinic Use Only

Confusion of similar words or letters Yes No _____

Reversals of words or letters when reading Yes No _____

Short attention span while reading Yes No _____

Rubs eyes during or after reading Yes No _____

Closes or covers one eye Yes No _____

Difficulty copying from chalkboard or book Yes No _____

Reverses letters or words when writing Yes No _____

Legible writing Yes No _____

Body Posture and Space Awareness

Unusual Awkwardness Yes No _____

Confuses Right and Left directions Yes No _____

General Behavior

Inattentiveness/Daydreaming Yes No _____

Unusual fatigue after completing a vision task Yes No _____

Frequent signs of frustration Yes No _____