PARENT'S CASE HISTORY FOR STUDENTS Date:_____

CHILD'S NAME: _____

(PLEASE DO NOT ASK YOUR CHILD TO HELP YOU FILL IN THIS QUESTIONAIRE)

Thank you for completing this history questionnaire. Often a child's perception of his problem may differ significantly from that of adults (parents, teachers, etc.) This difference often assists me in making recommendations best suited for your child. Please fill in the following checklist and questionnaire to the best of your ability. Thank you

Form completed by:._____
(Mom/Dad/Guardian)

What is the main reason for today's visit?_____

Do you feel that your child is having any problems at school? Explain:_____

_____

Are there any concerns from the teacher/psychologist? _____

_____

_____

Has he/she had any special testing in the past? i.e. psychological, occupational therapy, physiotherapy, speech/language.

Results:_____

_____

Family Visual History: (Please check if applicable)

_____ Extreme nearsightedness
_____ Extreme farsightedness
_____ Extreme astigmatism
_____ Turned eye (in/out)
_____ Lazy eye
_____ Glaucoma
_____ Cataracts
_____ Other vision problems:_____

_____

Reports of the examination are available upon request. Please ask the receptionist for an authorization form

CHILDS NAME:_____ DATE:_____

OBSERVABLE CLUES TO CLASSROOM
VISION PROBLEMS

1. APPEARANCE OF EYES

___ One eye turns in or out at any time

___ Reddened eyes or eyelids

___ Eyes tear excessively

___ Blinks excessively

2. COMPLAINTS WHEN USING EYES AT DESK:

___ Headaches in forehead or temples

___ Burning or itching after reading or desk work

___ Print blurs after reading a short time

3. BEHAVIORAL SIGNS OF VISUAL PROBLEMS:

A. Eye Movement Abilities (Ocular Motility)

___ Loses place often during reading

___ Needs finger or marker to keep place

___ Displays a short attention span in reading or copying

___ Too frequently omits words

___ Rereads or skips lines unknowingly

B. Eye Teaming Abilities (Binocularity)

___ Complaints of seeing double (diplopia)

___ Squints, closes or covers one eye

___ Tilts head extremely while working at desk

C. Eye-Hand Coordination Abilities

___ Writes crookedly, poorly spaced, cannot stay on ruled lines

___ Misaligns both horizontal and vertical series of numbers

____ Repeatedly confuses left - right directions

D. Visual Form Perception (Visual Comparison, Visual Imagery, Visualization)

___ Mistakes words with same or similar beginnings

___ Fails to recognize same word in next sentence

___ Reverses letters and/or words in writing copying

___ Repeatedly confuses similar beginnings and endings of words

E. Refractive Status (Nearsightedness, Farsightedness, Focus problems, etc.)

___ Holds book too closely; face too close to desk surface

___ Complains of discomfort when reading or looking at chalkboard

___ Works slowly when copying from chalkboard to paper on desk; makes errors

___ Squints to see chalkboard, or requests to move nearer

___ Rubs eyes during or after short periods of visual activity

OTHER OBSERVATIONS:

_____

_____

_____

Signed:_____
(Encircle): Parent, Teacher, Nurse, Remedial Teacher, Psychologist, Vision Consultant, Other