FAMILY VISION CARE OPTOMETRY

Child Questionnaire

Please fill out this questionnaire *carefully* and as thoroughly as possible. There are a total of 9 pages – please be sure you have completed all nine pages. You may either print a hard copy and bring it on the day of your appointment or fax it to us at 661-775-9627 prior to your appointment date. THANK YOU.

Date: _________________

Was your child referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? ____________________ Phone: _______________

Address: ____

A. GENERAL INFORMATION

Child's Full Name: ____

Male ☐ Female ☐ Birth Date: _____________________

Name and address of school: ____

____

Grade: ___ Teacher: ______________ School Nurse: _____________ Principal: ______________

Is your child especially afraid of doctors? Yes ☐ No ☐

Child's dominant hand: right ☐ left ☐ Has guidance been given in use of hand? Yes ☐ No ☐

Please list the names and ages of the child's siblings:

NAME: Age:

Sibling: _________________________________ _______________

Sibling: _________________________________ _______________

Sibling: _________________________________ _______________

B. RESPONSIBLE PERSON INFORMATION

Home Address: ____________________________________ City: ________________ Zip: ______

Home Phone: ________________________ Email Address: _______________________________

Name of Father/Caretaker: ______________________________ Cell phone: __________________

Father/Caretaker's Occupation: ________________________ Business Phone: ________________

Business Address: _________________________________ City: ________________ Zip: ______

Name of Mother/Caretaker: _______________________________ Cell phone: ___________________

Mother/Caretaker's Occupation: _________________________ Business Phone: _________________

Business Address: ___________________________________ City: _________________ Zip: ______

Vision Care Insurance: ________________________ Major Medical Insurance: ___________________

Subscriber's SS#/Member #: _____________________ Birth Date of Subscriber: _______________

C. MEDICAL HISTORY

Pediatrician's Name: ____________________________ Date of Last Evaluation: _________________

For what reason? ____

Results and recommendations: ____

____

Child's current state of health: ____

Medications currently using, including vitamins and supplements: _____________________________

____

For what condition(s)? ____

____

Any reactions to immunization(s)? Yes ☐ No ☐

If yes, explain: ____

List illnesses, bad falls, high fevers, etc.:

Age	Severe	Mild	Complications
__________	________________	___________________	______________________________
__________	________________	___________________	______________________________
__________	________________	___________________	______________________________

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐

If yes, please list: ____

Has a neurological evaluation been performed? Yes ☐ No ☐

By whom? _____________________________ Results and recommendations: __________________

____

Has a psychological evaluation been performed? Yes ☐ No ☐

By whom? ______________________________ Results and recommendations: __________________

____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐

By whom? ______________________________ Results and recommendations: __________________

____

Please indicate by checking the box whether anyone in your family has ever had any of the following and indicate who (including maternal and paternal grandparents, uncles, aunts, first cousins, mother, father, sister and brother):

Amblyopia ☐ ______	Arthritis ☐ ______	Blindness ☐ ______
Brain Tumor ☐ ______	Cancer ☐ ______	Cataracts ☐ ______
Cornea Problems ☐ ______	Corneal Transplant ☐ ______	Crossed/Lazy Eye ☐ ______
Detached Retina ☐ ______	Diabetes ☐ ______	Epilepsy / Seizures ☐ ______
Glaucoma ☐ ______	Heart Problems ☐ ______	High Blood Pressure ☐ ______
Keratoconus ☐ ______	Kidney Problems ☐ ______	Learning Disability ☐ ______
Macular Degeneration ☐ ______	Multiple Sclerosis ☐ ______	Stroke ☐ ______
TB ☐ ______	Thyroid Condition ☐ ______	Traumatic Brain Injury ☐ ______

D. NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Does your child: Like sweets ☐ or crave sweets ☐

If yes, what types? ____

Is your child active? Yes ☐ No ☐

moderately? Yes ☐ No ☐

extremely? Yes ☐ No ☐

Are there periods of

very high energy? Yes ☐ No ☐

very low energy? Yes ☐ No ☐

Explain: ____

____

E. DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐ Normal birth? Yes ☐ No ☐

Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐

If yes, explain: ____

Any complications before, during or immediately following delivery? Yes ☐ No ☐

If yes, explain: ____

Birth weight: ____________ Apgar scores @ birth: ____________ After 10 minutes: ___________

Were forceps used? Yes ☐ No ☐

Was there ever any reason for concern over your child's general development? Yes ☐ No ☐

If yes, why? ____

Was early speech clear to others? Yes ☐ No ☐ Is speech clear now? Yes ☐ No ☐

Where appropriate, list the age at which your child could do the following:

	Age		Age
Responsive smile	______	Stack Blocks	______
Crawl	______	Walks Alone	______
Roll Over	______	Scribble spontaneously	______
Creep (stomach on floor)	______	Kick a ball	______
Sit up alone	______	Walk up steps with help	______
Respond to words and names	______	Use 2 word sentences	______
Say single words	______	Become toilet trained	______
Give first name	______	Put on some clothing alone	______

F. VISUAL HISTORY

Has your child's vision been previously evaluated? Yes ☐ No ☐

If so, Doctor's Name: ______________________________ Date of last evaluation: ____________

Reason for examination: ____

Results and recommendations: ____

Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐

If yes, what? ____

Are they used? Yes ☐ No ☐

If yes, when? ____

If not used, why not? ____

Why do you feel your child needs a visual evaluation? ____________________________

How long has this problem/difficulty been observed? ____________________________

Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? Yes ☐ No ☐

If yes, what? ____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Any hobbies or sports that your child engages in: ______________________________

____

Does child watch TV? Yes ☐ No ☐ How often? ______________ Viewing distance? ________

Does your child spend time using computer/video games? Yes ☐ No ☐

If yes, How often? ______________ Viewing distance? ________

What other activities occupy your child's leisure time? ____________________________

____

Are there any activities your child would like to participate in, but doesn't? Yes ☐ No ☐

Please explain: ____

____

SCHOOL (only complete this section if child has started schooling)

Age at time of entrance to: Pre-school _______ Kindergarten _______ First Grade _______

Does your child like school? Yes ☐ No ☐

Specifically describe any school difficulties: ______________________________

____

Has your child changed schools often? Yes ☐ No ☐

If yes, when? ____

Has a grade been repeated? Yes ☐ No ☐

If yes, which and why? ____

Does your child seem to be under tension or pressure when doing school work? Yes ☐ No ☐

Has your child had any special tutoring, therapy, and/or remedial assistance? Yes ☐ No ☐

If yes, when and how long? ______________________________

Where and from whom? ______________________________

Results: ______________________________

Does your child like to read? Yes ☐ No ☐

What does he/she read? ______________________________

What is your child's attitude toward reading, school, his/her teachers, other youngsters? __________

____

Are there any behavior problems at school? Yes ☐ No ☐

If yes, what? ______________________________

Overall schoolwork is: above average ☐ average ☐ below average ☐

WHICH SUBJECTS ARE:

Above average: ______________________________

Average: ______________________________

Below average: ______________________________

Does your child need to spend a lot of time/effort to maintain this level of performance? Yes ☐ No ☐

How much time on average does your child spend each day on homework assignments? _________

To what extent do you assist your child with homework? ______________________________

Do you feel your child is achieving up to potential? Yes ☐ No ☐

Does the teacher feel your child is achieving up to potential? Yes ☐ No ☐

GENERAL BEHAVIOR

Are there any behavior problems at home? Yes ☐ No ☐

If yes, what? ______________________________

Child's reaction to fatigue? sag ☐ irritable ☐ other ☐ ______________________________

Child's reaction to tension? avoidance ☐ irritable ☐ other ☐ ______________________________

Does your child say and/or do things impulsively? Yes ☐ No ☐

Is your child in constant motion? Yes ☐ No ☐

Can your child sit still for long periods? Yes ☐ No ☐

FAMILY VISION CARE OPTOMETRY

FAMILY AND HOME

Please indicate which adult(s) he/she lives with?

Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parents ☐

Adoptive Parents ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐

Other Caretaker ☐ (please specify): ______________________________

Does your child spend time with any other person, not in the home? Yes ☐ No ☐

Please explain: ______________________________

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes ☐ No ☐ If yes, at what age: ________

Does your child seem to have adjusted? Yes ☐ No ☐

Was counseling /therapy undertaken? Yes ☐ No ☐ If yes, is it on-going? Yes ☐ No ☐

Is family life stable at this time? Yes ☐ No ☐

If no, please explain: ______________________________

How does your child get along with:

Parents/other caretakers? ______________________________

Siblings? ______________________________

Playmates at home? ______________________________

Did father or anyone in father's family have a learning problem? Yes ☐ No ☐

If yes, who? ______________________________

Did mother or anyone in mother's family have a learning problem? Yes ☐ No ☐

If yes, who? ______________________________

Do any, or did any, of the other children in the family have learning problems? Yes ☐ No ☐

If yes, who? ______________________________

To what extent? ______________________________

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

____

____

____

____

28089 Smyth Drive ¤ Valencia CA 91355 ¤ PH: (661) 775 1860 ¤ FAX: (661) 775 9627

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR TREATMENT OF YOUR CHILD?

____

____

____

____

____

____

LIFESTYLE CHECKLIST

Please assign a value between 0 and 4 for each symptom.

0 = never or non-existent / 1 = seldom / 2 = occasionally / 3 = frequently / 4 = always

Symptom	Value
1. Blurred vision	________
2. Double vision	________
3. Eyes hurt	________
4. Eyes tired	________
5. Headaches associated with near work	________
6. Words run together when reading	________
7. Burning, stinging, watery eyes	________
8. Falling asleep when reading	________
9. Frequent eye rubbing	________
10. Eye frequently reddened	________
11. Skipping or repeating lines when reading	________
12. Words move around on page when reading	________
13. Dizziness or nausea associated with near work	________
14. Head tilt or closing one eye when reading	________
15. Difficulty copying from the chalkboard	________
16. Avoidance of reading and near work	________
17. Omitting small words when reading	________
18. Writing uphill or downhill	________
19. Misaligning digits in columns of numbers	________
20. Reading comprehension declining over time	________

21. Inconsistent/poor sports performance	_______
22. Holding reading material too close	_______
23. Short attention span	_______
24. Difficulty completing assignments in reasonable time	_______
25. Saying “I can’t” before trying	_______
26. Avoiding sports and games	_______
27. Difficulty with hand tools (i.e. scissors, screwdrivers, calculator, keys)	_______
28. Reverses letters or words	_______
29. Tendency to knock things over on desk or table	_______
30. Motion sickness / car sickness	_______
31. Difficulty with time management	_______
32. Difficulty with money concepts and/or making change	_______
33. Misplaces or loses papers/objects, forgetful, poor memory	_______
34. Car sickness/ Motion sickness	_______
35. Reads slowly	_______
36. Uses finger as a marker to read	_______
37. Bothered by light	_______
38. Frequent blinking	_______
39. Confuses right and left	_______
40. Thumb-sucking	_______
41. Glum, sulky, moody, bad temper	_______