



# Brain & Eye Connection Vision Clinic, PC

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## CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Put N/A if not applicable or unknown.  
Please return it to our office prior to your appointment. **THANK YOU.**

Name of person filling out this form: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### GENERAL INFORMATION

Child's Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ years \_\_\_\_\_ months

### BILLING INFORMATION (Please put parent/guardian information if child is a minor)

Full Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mom's Cell: \_\_\_\_\_ Dad's Cell: \_\_\_\_\_

### GENERAL INFORMATION

Father/Caretaker \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN: \_\_\_\_\_  
Father/Caretaker's Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mother/Caretaker's Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Mother/Caretaker \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list the names and birth dates of your family members:

Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_  
Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_  
Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_  
Sibling \_\_\_\_\_ Birth Date \_\_\_\_\_

### REFERRAL INFORMATION

Were you referred to our office? Yes  No   
If yes, who may we thank for this referral? \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
If not referred, how did you hear about us? \_\_\_\_\_

### ACADEMIC INFORMATION

Name of school: \_\_\_\_\_  
Address of school: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Grade: \_\_\_\_\_ Home Room Teacher: \_\_\_\_\_ School Nurse: \_\_\_\_\_  
Principal: \_\_\_\_\_ School/Grade Counselor: \_\_\_\_\_  
Age at time of entrance to: Pre-school \_\_\_\_\_ Kindergarten \_\_\_\_\_ First Grade \_\_\_\_\_  
Has a grade been repeated? Yes  No   
If yes, which grade and why? \_\_\_\_\_  
Does your child generally like school? Yes  No

Does your child seem to be under tension or extreme pressure when doing schoolwork? \_\_\_\_\_  
Specifically describe any school difficulties: \_\_\_\_\_

Has your child changed schools often? Yes  No

If yes, when? \_\_\_\_\_

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

If yes, what age? \_\_\_\_\_ What grade? \_\_\_\_\_

Where and from whom? \_\_\_\_\_

How long? \_\_\_\_\_

Results: \_\_\_\_\_

Does your child like to read? Yes  No

Voluntarily? Yes  No  Does your child read for pleasure? Yes  No

What does your child like to read? \_\_\_\_\_

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

Overall schoolwork is: above average  average  below average

Does your child need to spend a lot of time/effort to maintain this level of performance?

Yes  No

Rank all of the subjects your child has in school:

Above average: \_\_\_\_\_

Average: \_\_\_\_\_

Below average: \_\_\_\_\_

Favorite subject: \_\_\_\_\_ Least Favorite subject: \_\_\_\_\_

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

## MEDICAL HISTORY

Is your child especially afraid of doctors? Yes  No

Pediatrician's Name: \_\_\_\_\_ Date of Last Evaluation: \_\_\_\_\_

Pediatrician's Address: \_\_\_\_\_

Reason for last visit? \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Child's current state of health: \_\_\_\_\_

Has your child ever been diagnosed with ADD or ADHD? Yes  No

If so, by whom? \_\_\_\_\_

Medications currently using, including vitamins and supplements: \_\_\_\_\_

For what condition(s)? \_\_\_\_\_

Medication Allergies: \_\_\_\_\_ Reaction to medications: \_\_\_\_\_

Immunizations child has received:

Immunization type: \_\_\_\_\_ Date: \_\_\_\_\_

Immunization type: \_\_\_\_\_ Date: \_\_\_\_\_

Immunization type: \_\_\_\_\_ Date: \_\_\_\_\_

Immunization type: \_\_\_\_\_ Date: \_\_\_\_\_

Any reactions to immunization(s)? Yes  No  If yes, explain: \_\_\_\_\_

**GENERAL HEALTH INFORMATION**

List all significant illnesses, bad falls, high fevers, head injuries, etc.:

Description Age Severity Complications

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Is your child generally healthy? Yes  No

If no, explain: \_\_\_\_\_

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

If yes, please list: \_\_\_\_\_

**SYSTEMIC HEALTH INFORMATION**

Check yes if you currently have or have had any significant problems in the following areas:

	Y	N		Y	N		Y	N
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine glands	<input type="checkbox"/>	<input type="checkbox"/>	Heart or Vascular	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	Chromosomal imbalance	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____			Diagnosed when? _____		

If you checked one or more of the above please explain further: \_\_\_\_\_

**FAMILY HISTORY INFORMATION**

Has anyone in your immediate family had or currently have any problems in the following areas:

(If yes, please list the family member(s) affected)

	Y	N		Y	N		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts at birth	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

If other please explain: \_\_\_\_\_

**FORMAL TESTING INFORMATION**

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: \_\_\_\_\_

Has a physical therapy evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

Has a speech/hearing evaluation been performed? Yes  No   
By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

Has educational testing been performed? Yes  No   
By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

### NUTRITIONAL INFORMATION

Does your child: Like sweets  or crave sweets

If yes, what types? \_\_\_\_\_

How active is your child? Mildly?  Moderately?  Extremely?

Are there periods of

very high energy? Yes  No  If so when? \_\_\_\_\_

very low energy? Yes  No  If so when? \_\_\_\_\_

Are there any food allergies/sensitivities? Yes  No

If so, explain: \_\_\_\_\_

### BIRTH & DELIVERY INFORMATION

Full-term pregnancy? Yes  No  If not, how long? \_\_\_\_\_

Was oxygen used after birth? Yes  No  If so, how long? \_\_\_\_\_

Type of delivery? Natural  C-Section  Other  Explain: \_\_\_\_\_

Were forceps used? Yes  No  Was anesthesia used? Yes  No

Did the mother experience any health problems during the pregnancy? (i.e. toxemia, trauma, use of alcohol, injury by fall, severe illness, smoking, use of drugs, little obstetrical care, prescription medication) 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: \_\_\_\_\_

Was your child alert as an infant? Yes  No  If not, explain: \_\_\_\_\_

### DEVELOPMENT INFORMATION

Were there ever any concerns regarding growth or development? Yes  No

If so, explain: \_\_\_\_\_

Did your child crawl (stomach on floor)? Yes  No  At what age? \_\_\_\_\_

If no, please explain: \_\_\_\_\_

Did your child creep (on all fours)? Yes  No  At what age? \_\_\_\_\_

If not, please explain: \_\_\_\_\_

At what age did your child sit up (without support)? \_\_\_\_\_

At what age did your child walk (without support)? \_\_\_\_\_

Was/is child active as a toddler? Yes  No  If not, describe: \_\_\_\_\_

Child's First words: \_\_\_\_\_ At what age: \_\_\_\_\_

At what age did your child speak in a simple sentence (string two words together)? \_\_\_\_\_

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

Did your child learn to ride a tricycle/bicycle? Yes  No  If yes, which? \_\_\_\_\_

At what age did your child learn to ride a tricycle? \_\_\_\_\_ At what age bicycle? \_\_\_\_\_

Did your child have difficulty learning to ride a tricycle/bicycle? Yes  No

If so, please explain: \_\_\_\_\_

Did your child have difficulty learning to run or skip? Yes  No

If so, please explain: \_\_\_\_\_

Did your child have difficulty learning to tie shoes or button clothes? Yes  No

If so, please explain: \_\_\_\_\_

Is your child generally well coordinated or clumsy? \_\_\_\_\_

If not well coordinated, please explain: \_\_\_\_\_

Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Yes  No

### LEISURE TIME ACTIVITIES

Does child watch TV? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

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

If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

How many hours does your child spend outside each day? \_\_\_\_\_

Does your child play any sports?

Which Sports \_\_\_\_\_ Performance in each? \_\_\_\_\_ Does your child wish to do better? If so describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What other activities/hobbies does your child enjoy? \_\_\_\_\_

\_\_\_\_\_

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

Please explain: \_\_\_\_\_

\_\_\_\_\_

### GENERAL BEHAVIOR

Are there any behavior problems at home? Yes  No

If yes, what? \_\_\_\_\_

Are there any behavior problems at school? Yes  No

If yes, what? \_\_\_\_\_

What causes these problems? \_\_\_\_\_

Child's reaction to fatigue? \_\_\_\_\_

Child's reaction to tension? \_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_

Is your child in constant motion? Yes  No

Can your child sit still for long periods? Yes  No

### FAMILY AND HOME LIFE

Please indicate which adult(s) he/she lives with? (check all that apply)

Mother  Stepmother  Grandmother  Aunt  Foster Parents

Father  Stepfather  Grandfather  Uncle  Adoptive Parents

Other Caretaker (please specify): \_\_\_\_\_

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

If so, who? \_\_\_\_\_

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 the following people: (describe any difficulties)

Parents/other caretakers? \_\_\_\_\_

Siblings? \_\_\_\_\_

Classmates in school? \_\_\_\_\_

Playmates at home? \_\_\_\_\_

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

If yes, please explain? \_\_\_\_\_

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

If yes, please explain? \_\_\_\_\_

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

If yes, who? \_\_\_\_\_

To what extent? \_\_\_\_\_

Has there been any treatment for it? Yes  No  Explain: \_\_\_\_\_

### **VISUAL HISTORY**

Have you had a previous vision evaluation? Yes  No  Date of last evaluation: \_\_\_\_\_

If yes, doctor's name: \_\_\_\_\_ Address: \_\_\_\_\_

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? \_\_\_\_\_

Do you feel your child's vision hinders his/her daily activities in any way? Yes  No

If yes, how? \_\_\_\_\_

If your child has an eye turn please fill out the additional questions regarding the eye turn.

## QUALITY OF LIFE SURVEY

Place a check in the box that corresponds to the frequency of each symptom your child has.

Symptoms	Never	Seldom (1-2x/mo)	Occasionally (3-5x/mo)	Frequently (2-3x/wk)	Always (4-5x/wk)
Blur when looking at near	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches with near work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Words run together when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning, itchy, watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls asleep when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees worse at the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skips/repeats lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy/Nausea with near work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head tilt/closes one eye when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty copying from far (i.e. chalkboard) to near (i.e. paper)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoids near work/reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Omits small words when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes up/down hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misaligns digits/columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading comprehension down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor/inconsistent in sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Holds reading material too close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble keeping attention on reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty completing assignments on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always says "I can't" before trying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoids sports/games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor eye/hand coordination (i.e. handwriting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not judge distance accurately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clumsy, knocks things over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not use his/her time well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not count or make change well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses belongings/things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car/motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetful/poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Office Use Only</b>	<b>Total</b>	_____	_____	_____	_____

**HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING IN YOUR CHILD:**

	<u>Yes</u>	<u>No</u>	<u>If yes, describe:</u>
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frowning/Facial distortions when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	<input type="checkbox"/>	Which eye? _____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head close to paper when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	How close? _____
Prefers being read to	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when reading	<input type="checkbox"/>	<input type="checkbox"/>	Direction of tilt? _____
Tilts head when writing	<input type="checkbox"/>	<input type="checkbox"/>	Direction of tilt? _____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses right and left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vocalizes when reading silently	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes neatly but slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does not support paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Awkward or immature pencil grip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent erasures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty recognizing same word on different page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor word attack skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Remembers better when hears than sees it	<input type="checkbox"/>	<input type="checkbox"/>	_____
Responds better orally than by writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems to know material, but tests poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with scissors / small hand tools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty catching / hitting a ball	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any other complaints your child makes concerning his/her vision:

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**GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:** \_\_\_\_\_

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

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Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us 24 hours a day/7 days a week. We request a minimum of 24 hour notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status.

I hereby give my permission to BRAIN & EYE CONNECTION VISION CLINIC, PC to treat \_\_\_\_\_ and also accept any and all financial responsibilities for services provided.

(Child's Name)

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

I acknowledge that the Notice of Privacy Practices is available at [www.brainandeyeconnection.com](http://www.brainandeyeconnection.com) or the office location where treatment is conducted and that I have read and understood the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided.

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

THANK YOU.  
CAROLANNE H. ROACH, OD  
CLINICAL DIRECTOR