



School Child Questionnaire



EYES
on **Oxford**
The EyeSense People

Name _____ DOB _____

Address _____

Teacher _____ School _____ Grade _____

Your Doctor _____ Contact Details _____

Phone no _____ Therapists Contact Details _____

_____ Referred by _____

Parents Name _____

PRESENT SITUATION

Brief summary of your main concerns _____

Please describe present health _____

Any family history of Diabetes Glaucoma Heart Disease Stroke

EDUCATIONAL PROGRESS

Has the child's progress been as expected for ability? _____

Does your child like school? _____ Does your child like to read? _____

Present reading level _____

What is your child's attitude to reading at home? _____

Do you consider school progress to be adequate or better? Yes No

What subject areas are most difficult? _____

What subjects are easiest? _____

Has the child been subjected to poor educational experiences? Yes No

Describe _____

Has s/he ever repeated a grade? _____ Has there been any remedial work? _____

Do you consider you child's co-ordination Average Above Below

Does your child play sport? _____ Which? _____

What activities does your child enjoy in leisure time? _____

HISTORY

Was pregnancy and birth free from complications? _____

Were there any problems in the following areas:

General growth/feeding _____

Health/emotional factors _____

Sleeping _____ Hearing _____





Language development _____

General co-ordination _____

Social behaviour _____

At what age did your child commence: Crawling on all fours _____

Walking _____ Talking _____ Show definite hand preference _____

VISUAL HISTORY

Has your child had previous visual examinations? _____ When? _____

Which practitioner? _____ Location? _____

Reason for examination? _____

Has your child had a turned eye? _____

Has your child ever received Visual Training? Yes No

Spectacles? Yes No

Other family members with visual difficulties:

Name _____ Age _____ Reason and result _____

Please place a check mark next to any problem that seems to occur often for this child:

SIGNS OF VISUAL SKILLS PROBLEMS

Covers or closes one eye when reading	
Rubs eyes	
Child complains of eyestrain	
Child complains of headaches	
Child complains of double vision	
Child complains of words moving on page	
Inattentive	
Poor reading comprehension	
Loses place	

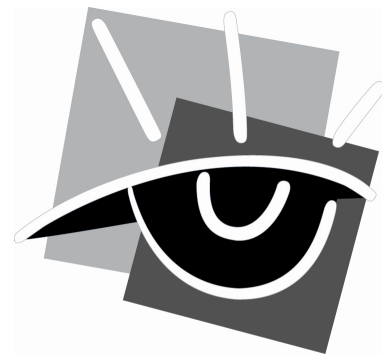
SIGNS OF VISUAL PROCESSING DISORDERS

Trouble learning left from right	
Reverses letters and numbers	
Mistakes words with similar beginnings	
Can't recognise the same word repeated on a page	
Trouble learning basic math concepts of size, magnitude	
Poor reading comprehension	
Poor recall of visually presented material	
Trouble with spelling and sight vocabulary	
Sloppy writing skills	
Trouble copying from board to book	
Erases excessively	
Can respond orally but not in writing	
Seems to know material but does poorly on written tests	
High activity level	
Impulsive	
Frustrates easily	
Doesn't listen when spoken to	

SIGNS OF FOCUSING PROBLEMS

Child complains of blurred vision	
Child complains of blurred vision when looking from desk to board	
Is tired at the end of the day	
Holds things very close	
Must use finger or guide to keep place	
Skips lines and words often	
Short attention span	

Any other comments:



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