

Dr. Emily Schottman  
Developmental Optometrist

Summer Beathe  
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### DEVELOPMENTAL VISION EVALUATION QUESTIONNAIRE - CHILD

Thank you for carefully completing this questionnaire, to personalize your child's care.

Please return it to our office one week before your appointment by email or regular mail.

Appointments without a questionnaire submitted will need to be rescheduled.

Patient's Name: \_\_\_\_\_ Developmental Vision Evaluation Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_ yrs. Gender: Male  Female  Were you referred to us? Yes  No

If you were referred, whom may we thank? \_\_\_\_\_

Referral Type: Doctor  Therapist  Tutor/Teacher  Family  Friend  Other: \_\_\_\_\_

If not referred, how did you hear about us? \_\_\_\_\_

#### YOUR CHILD'S CONTACT INFORMATION

Home Phone: \_\_\_\_\_ Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Child's Cell Phone: \_\_\_\_\_

Mother/Caretaker's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father/Caretaker's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

#### YOUR CHILD'S MEDICAL HISTORY

Pediatrician's Name: \_\_\_\_\_ Is your child especially afraid of doctors? Yes  No

Last Visit Date: \_\_\_\_\_ For what reason? \_\_\_\_\_ Is your child generally healthy? Yes  No

Medications (include vitamins/supplements): \_\_\_\_\_

Does your child receive immunizations? Yes  No  Are they up-to-date? Yes  No

List below any significant illnesses, bad falls, high fevers or chronic illnesses (asthma, allergies, frequent colds, ear infections).

Event/Condition	Age	Severity	Describe any complications

#### YOUR CHILD'S FAMILY HISTORY (Please check if there is any history of the following.)

	<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>		<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>
Poor Vision/Hi Rx	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus/ eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Issue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**YOUR CHILD'S VISUAL HISTORY:**

Has your child's vision been previously evaluated? Yes  No  If "Yes," Doctor's Name: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_ Results and recommendations: \_\_\_\_\_

Does your child wear: Glasses  Contacts  Both  Worn for which activities? \_\_\_\_\_

Has your child failed a school vision screening? \_\_\_\_\_

Does your child have academic difficulties? \_\_\_\_\_

Check all that apply:  Reading/reading comprehension  Writing  Increased Time to do homework  
 Behavioral issue  Not working up to potential  Dyslexia  ADD/ADHD Other: \_\_\_\_\_

Does your child report any of the following symptoms?	Yes	No	If "Yes," Explain.
Eyes Hurt	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches (please note time of day they occur)	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred vision / focus goes in and out	<input type="checkbox"/>	<input type="checkbox"/>	
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive To Bright Light/Sunlight	<input type="checkbox"/>	<input type="checkbox"/>	
Motion Sickness/Car Sickness	<input type="checkbox"/>	<input type="checkbox"/>	
Words Appear to "Swim" or Move when Reading/Writing	<input type="checkbox"/>	<input type="checkbox"/>	

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

Do you notice any of the following symptoms in your child?	Yes	No	If "Yes," Explain.
Red, watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Styes	<input type="checkbox"/>	<input type="checkbox"/>	
Tendency to Rub Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive Blinking or Squinting	<input type="checkbox"/>	<input type="checkbox"/>	
Frowning/ Wrinkled Forehead/ Face Tension	<input type="checkbox"/>	<input type="checkbox"/>	
An Eye that Turns In/Out	<input type="checkbox"/>	<input type="checkbox"/>	
Covers/Closes One Eye when Doing Near Tasks	<input type="checkbox"/>	<input type="checkbox"/>	
Move Objects Very Close to Look at Them	<input type="checkbox"/>	<input type="checkbox"/>	
Uses Finger as Marker to read	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with long periods of reading / writing	<input type="checkbox"/>	<input type="checkbox"/>	
Avoids reading	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of place when reading	<input type="checkbox"/>	<input type="checkbox"/>	
Confuses "Left" and "Right"	<input type="checkbox"/>	<input type="checkbox"/>	
Clumsy or uncoordinated	<input type="checkbox"/>	<input type="checkbox"/>	

Please describe any other visual symptoms that you notice: \_\_\_\_\_

## YOUR CHILD'S VISUAL HISTORY - EXTENDED

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 issue may be present? Yes  No

If "Yes," what? \_\_\_\_\_

**Do you or your child notice any of the following?** (Note: many of these symptoms fall into more than one category)

### Prescription/ Eye Focusing (Accommodation) Problem

- Blurry vision
- Difficulty focusing near/far (copying from chalkboard)
- Eyestrain, fatigue, headaches
- Frowns/squints or Facial tension
- Red eyes or lids
- Excessive watering of eyes or Eye rubbing
- Head close to paper when reading/writing
- Reading comprehension decreases with time

### Eye Tracking (Ocular Motility) Problem

- Skip words when reading
- Must reread to understand, especially when tired
- Use finger or marker when reading
- Loses place when reading
- Head movements when reading

### Eye Teaming (Binocularity) Problem

- One eye turns in/out (SEE ADDENDUM)
- See double, especially when tired
- Cover or close one eye when reading or writing
- Tilt or turns head
- Awkward posture when standing/reading/ writing
- Eyestrain or fatigue, especially at end of day
- Letters or lines "float" "run together," or "jump around"
- Holds objects too close/far

### Visual Motor Problem

- Write or print poorly (crooked, poor spacing, up/down)
- Writes neatly but slowly
- Awkward pencil grip
- Poor eye-hand coordination
- Clumsy, accident-prone
- Difficulty judging distances or objects
- Dislike/avoid sports

### Visual Information-Processing Problem

- Slow reader
- Confuses letters or words
- Difficulty recognizing same word on different page
- Mistakes words with similar beginnings
- Poor ability to remember what is read
- Seems to know material but does poorly on tests
- Reverses letters and numbers
- Learn better when "hear" the information
- Vocalizes or moves lips when reading silently
- Difficulty following verbal instructions
- Poor time management, always running behind
- Poor printing or handwriting
- Short attention span, distractible or loss of interest
- Confuse "right" and "left"
- Difficulty attending to detail

## YOUR CHILD'S DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes  No  Birth weight: \_\_\_\_\_ Apgar scores @ birth: \_\_\_\_\_ After 10 minutes: \_\_\_\_\_

Any pregnancy/delivery complications? Yes  No  If "Yes," explain: \_\_\_\_\_

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

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

At what age did your child walk? \_\_\_\_\_ Speech: First words: \_\_\_\_\_ At what age: \_\_\_\_\_

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

Child's dominant hand? Right  Left  Unknown  Has guidance been given in use of hand? Yes  No

Has there been any concern over your child's general growth or development? Yes  No

If "Yes," explain: \_\_\_\_\_

Have any of the following evaluations been performed?

Neurological evaluation? Yes  No  By whom? \_\_\_\_\_

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

Psychological evaluation? Yes  No  By whom? \_\_\_\_\_

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

Occupational therapy evaluation? Yes  No  By whom? \_\_\_\_\_

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

### YOUR CHILD'S SCHOOL AND READING HABITS

Age at time of entrance to: Pre-school \_\_\_\_\_ Kindergarten \_\_\_\_\_ First Grade \_\_\_\_\_ Current School Grade: \_\_\_\_\_

School Name: \_\_\_\_\_

Teacher Name: \_\_\_\_\_ School Nurse Name: \_\_\_\_\_

Principal Name: \_\_\_\_\_ In-School Educational Specialist Name: \_\_\_\_\_

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 like school? Yes  No  What parts? \_\_\_\_\_

Specifically describe any school difficulties: \_\_\_\_\_

Does your child seem to tense up when doing school work? Yes  No

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

If "Yes," when? \_\_\_\_\_

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

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

What were the results: \_\_\_\_\_

Does your child like to read? Yes  No  Does your child read voluntarily? Yes  No

If "Yes," what? \_\_\_\_\_

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

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? \_\_\_\_\_ hours

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

**YOUR CHILD'S GENERAL BEHAVIOR**

Are there any behavior problems at school? Yes  No  If "Yes," what are they and are there specific triggers? \_\_\_\_\_

Are there any behavior problems at home? Yes  No  If "Yes," what are they and are there specific triggers? \_\_\_\_\_

Child's reaction to fatigue? sad  irritable  other \_\_\_\_\_

Child's reaction to tension? avoidance  irritable  other \_\_\_\_\_

Does your child say and/or do things impulsively? Yes  No  Can your child sit still for long periods? Yes  No

What best describes your child's activity level? Inactive  Moderately active  Extremely active

**YOUR CHILD'S TELEVISION VIEWING/LEISURE TIME ACTIVITIES**

Does child watch TV? Yes  No  Average viewing time? \_\_\_\_\_ # of times a week? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

Use computer? Yes  No  Average viewing time? \_\_\_\_\_ # of times a week? \_\_\_\_\_ Viewing distance? \_\_\_\_\_

Play video games? Yes  No  Average viewing time? \_\_\_\_\_ # of times a week? \_\_\_\_\_ 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: \_\_\_\_\_

**YOUR CHILD'S NUTRITIONAL INFORMATION**

Current Diet: Excellent  Good  Fair  Poor

Does your child: Like sweets  or Crave sweets  If "Yes," what types? \_\_\_\_\_

Has your child tested positive for Food Allergies? If so, which foods? \_\_\_\_\_

**YOUR CHILD'S 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: \_\_\_\_\_

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

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

Does the child have any siblings? Yes  No  Names and ages? \_\_\_\_\_

Has your child ever been through a traumatic family situation (separation/divorce, parental loss, separation from parents, severe parental illness)? Yes  No  Please explain: \_\_\_\_\_

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: \_\_\_\_\_

Does your child get along well with: Parents/other caretakers? Yes  No  Siblings? Yes  No

Classmates in school? Yes  No  Playmates at home? Yes  No

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

WHAT ARE YOUR BIGGEST CONCERNS REGARDING YOUR CHILD AT THIS TIME? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT IS YOUR GOAL FOR YOUR CHILD'S VISUAL EVALUATION AND/OR VISION TRAINING?  
\_\_\_\_\_  
\_\_\_\_\_

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 require a minimum of 24 hours notice if you are unable to keep this appointment. **If < 24 hours, there is a \$45 rescheduling fee to reappoint a missed appointment. A missed initial appointment with no notice will not be rescheduled.**

Please be on time for your appointment, so that we will have the maximum opportunity to evaluate your child's vision. Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

We are looking forward to meeting you.

Thank you.



Dr. Emily Schottman  
Developmental Optometrist

Developmental Optometrists specialize in the testing and training of visual skills used for improved performance in school, work and sports/hobbies, providing a more enjoyable quality of life.

## STRABISMUS/AMBLYOPIA ADDENDUM

(Please complete if applicable)

Have you ever been told that your child has amblyopia ("lazy eye")? Yes  No  If "Yes," at what age? \_\_\_\_\_

Have you ever been told that your child has strabismus ("lazy eye")? Yes  No  If "Yes," at what age? \_\_\_\_\_

Have your child had an eye surgery? Yes  No  If "Yes," please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on: \_\_\_\_\_

Was the surgeon satisfied with the results of surgery? Yes  No  Explain: \_\_\_\_\_

Were you satisfied with the results of surgery? Yes  No  Explain: \_\_\_\_\_

Have surgical results been maintained? Yes  No  Explain: \_\_\_\_\_

Are you here for a second opinion regarding surgery or other treatment? Yes  No

### IF YOUR CHILD'S EYE TURNS:

▪ At what age did you first notice or suspect that was an eye turning? \_\_\_\_\_

▪ Did it begin turning: suddenly  or gradually ? Explain: \_\_\_\_\_

**Note: a sudden eye turn may be due a serious medical emergency and requires immediate medical attention. Call 911.**

▪ Does the eye turn: in  out  up  or down ? (check all that apply)

▪ Is the eye turn getting: worse  or better  or is there no change ?

▪ Is it always the same eye that turns? Yes  No  If "Yes," which eye? Right  Left

▪ Is the eye turn always present? Yes  No  If no, under what conditions is it present? \_\_\_\_\_

▪ Does the eye always turn the same amount? Yes  No  If no, explain: \_\_\_\_\_

▪ Do you notice if the eye turns more when your child is looking:

○ up close? Yes  No

○ in the distance? Yes  No

○ to the left? Yes  No

○ to the right? Yes  No

○ up? Yes  No

○ down? Yes  No

Does the eye turn less (or vision improve) when the prescription is worn? Yes  No  Unsure

Has your child ever used an eye patch? Yes  No

If "Yes," please describe your age when the patching was started, how the patching was done and for how long, the eye patched, and an estimate of the results: \_\_\_\_\_

Does one pupil ever appear to be larger than the other? Yes  No

Do you ever notice one or both eyes shaking rapidly? Yes  No

What is your child's best corrected vision, if known? \_\_\_\_\_

What are your biggest concerns regarding your Child's Strabismus or Amblyopia? \_\_\_\_\_

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## RELEASE OF INFORMATION

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH YOUR CHILD'S SCHOOL AND/OR OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers or insurance carriers upon their written request or upon the recommendation of the STARS IN YOUR EYES OPTOMETRY when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Emily Schottman and STARS IN YOUR EYES OPTOMETRY to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

I hereby give my permission to STARS IN YOUR EYES OPTOMETRY to treat \_\_\_\_\_.  
Child's Name

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

\_\_\_\_\_  
Date