Pre - Assessment Questionnaire

This questionnaire will allow me to plan for your appointment. Please fill in as much as you can.

Today's Date: ..... / ..... / .....

Child's Full Name .....

Date of Birth ..... / ..... / .....

Home Address .....

.....

Postcode .....

Telephone Number .....

Email address .....

School Name .....

GP Name & Surgery: .....

Parents' Names: .....

.....

What are the main concerns that led you to seeking my help?

Previous Visual History

Has there been any previous eye/visual care? Yes / No

If yes, please give details e.g. information on glasses, any orthoptic exercises, surgery, patching etc. that might have been used.

Date of last sight test ..... / ..... / ..... (approximate)

If spectacles have been prescribed, are they still worn? Yes / No

If you have a copy of the current spectacle prescription, please bring it to the exam.

Observations

Have you observed any of the following? Or has your child reported doing any of the following?	Never	Some times	Often	Always	N/A, Don't know
Skip over or omit words when reading					
Use finger or bookmark to help keep place					
Loses place when reading or rereads the same line or word					
Complains of blurred vision whilst reading					
Complains of print doubling, "running together, "words jumping" or "wobbling about"					
Complains of headaches with visual tasks					
One eye turning in, out, up or down at any time					
Excessive tiredness during or after close work					
Pain or discomfort around the eyes with close work					
Reddened eyes or lids or excessive eye rubbing or blinking					
Frowning, scowling or squinting with visual tasks					
Closing or covering one eye, either when working, or viewing from a distance					
Moving in and out when working					
Moving very close to work or holding books very close					
Loses concentration when doing close work					
Avoids close work					
Reads very slowly					
Has trouble remembering what he/she read					
Reversal of letters/words or numbers when reading e.g. saw/was, 12/21, d/b, etc.					
Difficulty in copying from whiteboard					

Have you observed any of the following? Or has your child reported doing any of the following?	**Never**	**Some times**	**Often**	**Always**	**N/A, Don't know**
Difficulty with co-ordination					
Problems with balance					
Untidy handwriting					
Discomfort in hand when writing					
Letters formed backwards when writing					
Difficulties with spelling					
Are spelling errors generally phonetic?					
Does the child have a short attention span?					
Is the child prone to daydreaming?					
Is the child disruptive in class?					
Is the child clumsy / knocks things over?					
Is the child prone to travel sickness?					

Family History

Is there any family history of visual problems? Yes / No *If yes, please give details.*

Is there any family history of dyslexia or learning difficulty? Yes / No *If yes, please give details.*

Is there any family history of hyperactivity, attention difficulties or speech problems? Yes / No *If yes, please give details.*

Pregnancy and Birth History

Have there been any complications during the pregnancy? (eg need for bedrest?)

Was birth premature? Yes / No

Birth Weight? .....

Was the child delivered by C-Section? Yes / No *If yes, what was the reason for the C-Section?*

Were there any complications at or shortly after birth? Yes / No *If yes, please give details.*

Was the child conceived through IVF? Yes / No

General History

At what age did your child Crawl? ..... Walk? ..... Talk? .....

Have there been any behavioural problems? Yes / No *If yes, please give details.*

Have there been any hearing problems? Yes / No *If yes, please give details.*

Have grommets been used? Yes / No
Is the child's hearing now normal?

Was speech therapy needed? Yes / No *If yes, please give details.*

Does your child have any health problems? Yes / No *If yes, please give details.*

Does the child take any regular/prescribed medication? Yes/No *If yes, please give details.*

Does your child suffer from any allergies? Yes / No *If yes, please give details.*

Does your child have any nutritional / eating problems? Yes / No *If yes, please give details.*

Does your child display a good/healthy sleeping pattern? Yes / No

How much time on avearge does your child spend on VDU screens for recreational purpose (includes TV, Games Console, Social Media, PC, Laptop, phone and tablet use)?

Weekdays? ……hours/day

Weekends and Holidays?.....hours/day

What are your child's special interests and hobbies?

Laterality

Is your child left-handed ..... right-handed ..... ambidextrous .....?

Hand Dominance in family

Father left handed ..... right handed ..... ambidextrous .....?

Mother left-handed ..... right-handed ..... ambidextrous .....?

Siblings

- 1 left-handed ..... right-handed ..... ambidextrous .....?
- 2 left-handed ..... right-handed ..... ambidextrous .....?
- 3 left-handed ..... right-handed ..... ambidextrous .....?

Does child confuse directions and lefts and rights? Yes / No

School

Have your child's school expressed any concerns about academic progress?

Is your child receiving extra support either in or out of school?

Have any other tests been carried out? Yes / No
(e.g. educational psychological evaluation)
If yes, please could you let me see a copy of any reports that have been prepared.

In your opinion, what are your child's

- Best subjects?

- Worst subjects?

Does your child enjoy school? Yes / No

Are you satisfied with your child's school performance Yes / No

Does your child read as well as their peer group in school? Yes / No

Does your child read as well as their brothers and sisters? Yes / No

Are there any other factors, or further information you feel would be of help to me? (eg. bereavement, family dynamics, emotional or physical trauma, ect)

How have you heard of my services?

Thank you for taking the time to complete this questionnaire

The information given will help prepare for your appointment and aid in planning the most appropriate tests to use.

Terms and Conditions

Please note my cancellation and missed appointments policy: Appointments can be moved or cancelled free of charge providing the request is made more than 48 hours prior to the appointment. Failure to attend without notice or appointments cancelled within less than 48 hours will be charged in full.

The information gathered in this questionnaire and during the assessment and treatment of your child may be used for research and auditing purposes. This will always be done in an anonymised way.

It is sometimes beneficial to discuss examination results with other professionals working with your child; please sign below to authorise this exchange of information and accept above terms and conditions.

Signature ..... Date .....

Relation to child .....