# Children's Vision Questionnaire

## General Information

Mother's Full Name:______________________________________________________________

Father's Full Name:______________________________________________________________

School:________________________________________________________ Grade: _____________

Teacher: _________________________________ Principal: ________________________________

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

## Medical History

Has a psychological/neuropsychological evaluation been performed? ☐ Yes ☐ No

If yes, by whom? ________________________________________________________________

## Does your child currently receive

Occupational therapy services: ☐ Yes ☐ No By whom? _______________________________

Physical therapy services: ☐ Yes ☐ No By whom? _______________________________

Speech therapy services: ☐ Yes ☐ No By whom? _______________________________

Tutoring or Special Education: ☐ Yes ☐ No By whom? _______________________________

Does your child currently have an IEP/504 plan in place? ☐ Yes ☐ No

## Developmental History

Full term pregnancy? ☐ Yes ☐ No If no, weeks of gestation at delivery:_________________

Normal Birth? ☐ Yes ☐ No Birth Weight:_______________

Was the child adopted? ☐ Yes ☐ No If yes, age at which child started living with you: ______

Complications during or after delivery? ☐ Yes ☐ No

Did your child walk by 18 months of age? ☐ Yes ☐ No

Did your child try to imitate words by age 12 months? ☐ Yes ☐ No

Was your child's speech clear to others? ☐ Yes ☐ No Is it clear now? ☐ Yes ☐ No

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, which grade?_________________