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Parent Questionnaire

Child's Name:
Completed By:
Date

Don't worry about being overly detailed. Don't concern yourself with providing answers to all questions. Use this questionnaire as a guide to focus your thoughts on what you feel the trouble is. Provide as much detail as you reasonably can.

A. PRIMARY CONCERNS

1. In your own words, please state briefly your main concerns, and the trouble your child is having.
2. What has occurred that has led you to request this assessment?
3. How was this problem identified? When?
4. Who referred you to our clinic? How did you hear about us?

B. VISUAL HISTORY

1. Has there been previous visual care? Please describe in detail (include any information about glasses, patching, vision therapy, medication, or surgery, 'lazy eye'.)
2. Regarding your child's eyes and vision, please give your thoughts regarding the following statements. For the following table, **0 = Never**, **4 = all the time**.

Symptom - Does the child...	**0**	**1**	**2**	**3**	**4**
report that his/her eyes feel tired when reading or doing close work?					
report that his/her eyes feel uncomfortable or sore/hurt when reading or doing close work?					
report headaches when reading or doing close work?					
report that he/she feels sleepy when reading or doing close work?					
report that she/he has trouble remembering what she/he has read?					
report double vision when reading or doing close work or at any other time?					
Report that words move, jump, swim, or appear to float on the page when reading or doing close work?					

Symptom - Does the child...	0	1	2	3	4
read slowly?					
use a finger or a straight edge, like a ruler, to read?					
report a 'pulling' feeling around his/her/eyes when reading or doing close work?					
report that words blur or come in and out of focus when reading or doing close work?					
lose his/her place while reading or doing close work?					
have to re-read over words or sentences when reading?					
make reversal errors when reading (was for saw, on for no) or in writing (b for d)?					
transpose numbers (12 for 21)?					
have difficulty copying written material?					
have poor printing or cursive writing?					
avoid reading?					
have difficulty finishing school assignments in a timely fashion?					
misalign digits or columns when doing math assignments?					
seem to be clumsy or knock things over?					
overlook small details (reads 'beak' for 'break') or misread math symbols ('-' for "+")?					
have a short attention span or is she/he easily distractible when reading or studying?					
have trouble sitting still for more than 5 to 10minutes?					

Notes:

C. DEVELOPMENTAL / HEALTH HISTORY

1. Were there any complications with pregnancy or at birth? If yes, please explain.
2. Was your child born prematurely? If yes, what was the length of the pregnancy?
3. Child's birth weight:
4. Was there any maternal use of or exposure to alcohol, drugs (prescription and nonprescription), or cigarettes during the pregnancy? If yes, please explain.
5. At what age did the child
   - crawl on all fours?
   - pull him/herself up to chairs and tables?
   - walk?
   - make first speech sounds?

6. What were the child's first words/phrases?
7. Was speech clear? Did/do others have trouble understanding your child's speech?
8. Is speech adequate today?
9. Can your child:
   - dress him/herself?
   - button clothes?
   - tie bows?
   - zip zippers?
   - lace shoes?
   - Child could do these before entering school.

10. Does your child have any developmental or genetic disorders?
11. Did your child have any early behavioural problems (temper tantrums, self-destructive behaviours, difficulty sleeping, etc.). If yes, please explain.
12. Have there been any severe childhood illnesses, high fever, injury, or physical impairment? If yes, please explain.
13. Has the child had any ear infections? If yes, please indicate how often and whether any treatment was received?
14. Does the child have any allergies to food, medications, or environmental allergies? If yes, please indicate to what and any treatment he or she is receiving.
15. Has your child ever had a neurological evaluation? If yes, please explain when, why, and the results.
16. Does your child have a history of epilepsy or seizures?
17. What medications (such as penicillin or sulfa drugs) have been given and for what?
18. Has your child ever had a reaction to medication? If yes, provide details.
19. Is your child receiving any medications, supplements, or medical care currently? Please provide details.
20. Has your child ever had a speech/language evaluation or therapy?
21. Has your child ever had an occupational therapy evaluation and/or therapy?
22. Does your child have frequent periods of extreme fatigue? If yes, when?
23. Does fatigue generally result in sluggishness, excitability, or irritability?
24. Does your child exhibit any tensional behaviour such as nail biting, eye blinking or rubbing, tantrums, tongue chewing, teeth grinding, lip biting? If so, when?
25. If you child good with his/her hands (for present age)? Is block play good? Do building sets, puzzles, coloring and cutting hold the child's attention?

26. Does the child like to participate in sports activities?
27. Does your family read?
28. Do you read with your child? How often?
29. Is there a family history of hyperactivity, attention problems, or speech difficulties? Who? Provide details.
30. Is there a family history of significant reading, writing, or spelling difficulties?
31. Has your child been evaluated by a pediatrician or other medical specialty?
32. When was your child last seen by your family doctor?

Notes:

D. EDUCATION HISTORY

1. Has your child ever had a psychoeducational assessment, or received special testing at school? Please provide details, including results.
2. At what age did your child begin nursery/play school?
3. Did your child attend Kindergarten? At what age?
4. At what age did your child begin Grade 1?
5. Has your child ever skipped a grade or been held back a grade? Provide details.
6. Provide a history of schools your child has attended, including names or towns/cities.
7. Has your child had any evaluations (psychological, special educational, etc.) at school? If yes, indicate when and the results. You will be asked for copies of these assessments prior to commencement of therapy.
8. Does your child receive any special services from the school (speech and language, occupational therapy, reading remediation, etc.)? If yes, indicate type and how often.
9. Is your child in a specialized classroom setting (self-contained, resource, etc.)? If yes, please provide details.
10. Does your child receive private tutoring?
11. How is your child getting along in school?
12. In your opinion, what is his/her
    - best subject?
    - Easiest subject?
    - Hardest subject?

13. If there is difficulty at school, what do you think is the reason?
14. What does your child report about school or school work?
15. What do teachers report regarding your child's school work?
16. Does your child like school?
17. Does your child like his/her teacher?
18. Is the school satisfied with your child's performance?
19. Are you satisfied with your child's performance?
20. Does your child attend school regularly?
21. Has your child ever missed more than a couple of days of school at a time, or more than 10 days in a year?
22. Is his/her performance up to potential?
23. Is your child attending the grade level expected for his/her age?
24. Does your child read as well as others in the same grade?
25. … or as well as brothers and sisters?

E. ENVIRONMENTAL INFORMATION

1. Does your child have any allergies to foods or cleaners?
2. Is your child bullied at school?
3. Has there been any significant trauma in your child's life including deaths, divorce, accidents? Please provide details.
4. What does your child like to play with?

Please provide the name of your child's school, teachers and the subjects they teach.

PLEASE INCLUDE ANY ADDITIONAL COMMENTS OR NOTES YOU FEEL WOULD BE HELPFUL.