Welcome to Light Optometry & Vision Therapy
We would like to learn more about your Child.

Title (please circle) Miss Mstr	Given names	Surname
Preferred name (if different from above)	Date of Birth	
Residential address		
Postal address (if different from above)		

Parent's / Guardian's Contact Details		
Parent's / Guardian's names:		
Phone (home)	Mobile:	Work
Email:		Date:
Name of person filling in this questionnaire	Relationship to child	

Medicare number	Child's Reference number	Expiry
Person responsible for payment (if different from above)	Parent's Reference number	Parent's date of birth
School	Teacher's name	Grade
Who suggested your child should visit us?	Do you or your child's teacher / therapist suspect that your child may have a vision problem? If yes, please explain.	
General Practitioner	Address	Contact number

Please tick the boxes that apply to your child – their complaints or what you or their teacher / therapist may have observed

Reading		Spelling		Writing		Maths	

Signs of Eye Teaming Difficulties (Binocular Vision)

Covers or closes one eye when reading		Complains of double vision		Misaligns digits in number columns	
Head tilt when working		Complains of words moving on the page		Repeats letters within words	

Signs of Focussing Difficulties

Blurred vision when reading		Excessively short working distance		Complains of blurred vision on board	
Blur when looking from desk to board		Blinks excessively only when reading		Screws up eyes or blinks to see board	
Complains of discomfort in tasks that demand visual interpretation		Reduced comprehension as reading continues		Trouble copying from board – slow or errors	
Is tired at end of school day		Rubs eyes		Requests to move closer to board	

Signs of eye movement (tracking) difficulties

Loses place often		Needs finger or marker to keep place		Omits words frequently, esp 'small' words	
Rereads or skips lines and words often		Head turns to read across page			

Other visual related difficulties

Complains of headache		Awkward posture when reading		Short attention span when reading	
Complains of eyestrain		Awkward posture when writing		Inattentive	
Poor reading comprehension		Avoids reading or other near visual tasks		Light sensitivity	

Signs of Visual Processing Difficulties

Confusion with left and right		Mistakes words with similar beginnings		Untidy writing	
Reversals – letters &/or numbers		Trouble with spelling & / or sight words		Writing crooked or poorly spaced	
Poor recall of visually presented material		Slow copying and completing worksheets		Erases excessively	
Seems to know material, but performs poorly on written tests		Doesn't recognise the same word repeated on a page		Uses hand or finger as 'spacer'	
Can respond orally, but not in writing		Cannot follow sequential instructions		Is disorganised	
Whispers to self in silent reading		Draws with fingers in air before writing		Orientates drawings poorly on page	

Appearance of eyes

One eye turned in or out		Red eyes		Crusting on eye lids	
Frequent styes on infections		Frequent or unusual eye movements		Excessive watering of eyes	

Other

Please specify:

If any of these apply to your child, please tick 'YES' and provide brief details (otherwise leave blank):

Prenatal / Birth / Postnatal History	YES	If yes, please provide brief details
Any difficulties during pregnancy?		
Any difficulties with Mum's health during pregnancy?		
Born premature or overdue?		
Birth process unusual or difficult?		
Caesarean or emergency caesarean?		
Forceps used?		
APGAR score 6 or below?		
Post-natal jaundice?		
Low birth weight or poor weight gain?		
Any post-natal health difficulties?		
Development		
Over-active or underactive?		
Didn't crawl on stomach (commando crawl)?		
Didn't crawl on hands and knees?		
Bottom-shuffler or other variation of crawling?		
Walked early (before 10 months) or late (after 16 months)?		
Talked early or late (expected is 2-3 word phrases by 2 years)?		
Difficulty learning to dress themselves?		
Difficulty learning to ride a push bike?		
Health		
Any present health concerns?		
Any major health events?		
Present or regular medication?		
Any allergies or intolerances?		
Chronic or recurrent illness or syndromes (eg asthma, epilepsy)?		
History of ear problems &/or grommets?		
Previous eye treatment – glasses, patching, vision therapy, surgery?		
Attends or attended Occupational Therapy?		
Attends or attended Speech Therapy?		
Other relevant assessments?		
Suffers from travel sickness?		
Energy levels inadequate?		
School		
Dislikes school?		
Problems learning to read in 1st 2 years of school?		
Problems learning to write in 1st 2 years of school?		
Difficulty in catching a ball or other eye-hand co-ordination problems?		
Prefers outside to indoor activities?		
Any diagnosis – ADD, ADHD, Dyslexia, Dyspraxia, ASD?		
Progress at school not as expected? Grade repeated?		
Social		
Socially inactive?		
Any very stressful life incidents?		
Behavioural issues?		
Family history of learning difficulties?		
Other		
Any other information that you would like to share?		

Submit

At Light Optometry and Vision Therapy your privacy is important to us. Your personal information that we collect and hold about you is handled with confidentiality and security and in accordance with the Privacy Act.

Very occasionally we may send out information on education relating to eye care and disease, promotional offers, invitations to events and our practice newsletter. Do we have your permission to send this material to you?

☐ Yes ☐ No If yes, how would you prefer this sent: SMS email mail