InSight Developmental Vision Questionnaire

Name_____Date of Birth_____
First Name MI Last Name

Address_____SS#_____
Street City State Zip

Child's Father_____Phone: Home_____ Cell/Work_____

Child's Mother_____Phone: Home_____ Cell/Work_____

Parents ☐ Married ☐ Separated ☐ Divorced ☐ _____ Child lives with_____

Siblings (with ages)_____

Patient's Grade: _____School:_____Teacher:_____

Has your child repeated grades ☐ No ☐ Yes ☐Grade_____

Date of last routine health appt _____ Name of Regular Physician _____

HAS YOUR CHILD EVER HAD ☐ Eye Surgery ☐ Vision Therapy ☐ Patching ☐ Contacts ☐Glasses ☐ Atropine

DOES THE CHILD USE ANY EYEDROPS?_____

Current Services that your child is enrolled in:

Occupational Therapy	☐ No	☐ Yes	☐ School	☐ Private	Frequency_____
Physical Therapy	☐ No	☐ Yes	☐ School	☐ Private	Frequency_____
Tutoring in Math	☐ No	☐ Yes	☐ School	☐ Private	Frequency_____
Tutoring in Reading	☐ No	☐ Yes	☐ School	☐ Private	Frequency_____
Vision Therapy	☐ No	☐ Yes	☐ School	☐ Private	Frequency_____
Speech Therapy	☐ No	☐ Yes	☐ School	☐ Private	Frequency_____

Child's Reading Level_____ **Child's Math Level**_____

Child's Overall School Performance: ☐Below Average ☐ Average ☐ Above Average ☐ Unsure

Is Child Performing to Potential: ☐ No ☐ Yes ☐ Unsure

Does your child have an IEP: ☐ No ☐ Yes

Does your child have an 504: ☐ No ☐ Yes

MY CHILD IS HERE TODAY BECAUSE (please check all that apply):

☐ No Problems – General Check-Up	☐ Family History of Visual Condition	☐ Initial Consult/Visit
☐ Eye Turns: IN or OUT (circle which)	☐ Squints a Lot	☐ Second Opinion
☐ Rubs Eyes a Lot	☐ Eyes Do Not Seem to Focus	☐ Other_____

DEVELOPMENTAL HISTORY

1. My child is: _____Natural. _____Adopted. _____Foster. _____Other_____
2. Are there any known genetic of familial disorders? ☐ No ☐ Yes
   Please explain_____
3. During the pregnancy of this **child,** were there any complications? ☐ No ☐ Yes
   Please explain_____
4. Was there a need for oxygen at birth? ☐ No ☐ Yes
5. Was the **child** born prematurely? ☐ No ☐ Yes, If Yes, How Many Weeks?_____
6. Type of delivery: _____Normal. _____Caesarian. _____Forceps or instruments. _____Anesthesia.
   Other (please explain)_____
7. What was the child's birth weight? _____Pounds_____Ounces

8. Was there any use of cigarettes, alcohol, drugs, or medications during the pregnancy? ☐ No ☐ Yes
   Please explain_____

9. At what age did your child:

	Average Ages
Sit up unassisted_____	5-6 months
Start crawling_____	7-10 months
Begin to walk_____	11-15 months
Make speech sounds_____	12-22 months

10. Is your **child's** speech adequate now? ☐ Yes ☐ No Explain:_____
11. Does your **child** have, or at one time had any behavioral problems such as temper tantrums, self-destructive behavior, difficulty sleeping, etc? ☐ No ☐ Yes Explain:_____
12. Is the **child** developmentally delayed? ☐ No ☐ Yes Explain:_____
13. Has the **child** been diagnosed with the following?
    ☐ ADD ☐ ADHD ☐ Autism ☐ Other Personality Traits_____
14. What hand does your child use for eating, writing, throwing? ☐ Right ☐ Left ☐ No Preference
15. Is there any information you prefer to discuss without your child being present? ☐ No ☐ Yes
    Explain:_____

Functional Vision Questionnaire (circle response)	Never	Seldom	Occasional	Frequently	Always
Blur when looking near	0	1	2	3	4
Double vision, doubled or overlapping words on page	0	1	2	3	4
Headaches while or after doing near vision work	0	1	2	3	4
Words appear to run together when reading	0	1	2	3	4
Burning, itching or watery eyes	0	1	2	3	4
Falls asleep when reading	0	1	2	3	4
Seeing and visual work is worse at the end of the day	0	1	2	3	4
Skips or repeats lines while reading	0	1	2	3	4
Dizziness or nausea when doing near work	0	1	2	3	4
Head tilts or one eye is closed or covered while reading	0	1	2	3	4
Difficulty copying from the board	0	1	2	3	4
Avoids doing near vision work such as reading	0	1	2	3	4
Omits (drops out) small words while reading	0	1	2	3	4
Writes up or down hill	0	1	2	3	4
Misaligns digits or columns of numbers	0	1	2	3	4
Reading comprehension low, or declines as day wears on	0	1	2	3	4
Poor, inconsistent performance in sports	0	1	2	3	4
Holds books too close, leans too close to computer screen	0	1	2	3	4
Trouble keeping attention centered on reading	0	1	2	3	4
Difficulty completing assignments on time	0	1	2	3	4
First response is "I can't" before trying	0	1	2	3	4
Avoids sports and games	0	1	2	3	4
Poor eye-hand coordination, such as poor handwriting	0	1	2	3	4
Does not judge distances accurately	0	1	2	3	4
Clumsy, accident prone, knocks things over	0	1	2	3	4
Does not use or plan his/her time well	0	1	2	3	4
Does not count or make change well	0	1	2	3	4
Loses belongings and things	0	1	2	3	4
Car or motion sickness	0	1	2	3	4
Forgetful, poor memory	0	1	2	3	4

I attest that the information included on this form is correct to the best of my knowledge.

Parent/Legal Guardian Signature:_____ Date:_____