**CONFIDENTIAL**

**Pre-Vison Assessment Questionnaire**

The purpose of this questionnaire is to help us tailor aspects of the assessment to your child’s specific needs and so make this as useful as possible for them. Please answer as much of this questionnaire as possible. Don’t worry if you cannot answer all the questions. If you are not sure, just leave them blank, and we will discuss any uncertainties with you at the assessment. Please complete the visual symptoms and headache sections by asking your child. This questionnaire must reach us no later than two working days prior to your assessment.

**Email is our preferred means of communication so please email this completed questionnaire and any other documents to** [**therapy@keithmurphyopticians.co.uk**](mailto:therapy@keithmurphyopticians.co.uk) **and you will receive a response within ten working days.**

|  |  |
| --- | --- |
| Patient’s Name |  |
| Date of Birth |  |
| Address  Post Code |  |
| Telephone Number |  |
| Mobile Number |  |
| Email Address |  |

|  |  |
| --- | --- |
| Name & Address of person who referred you to us |  |
| Name & Address of GP |  |
| Name & Address of School/College |  |
| Classes/Course & Name of Form Tutor |  |
| Name of School’s Special Educational Needs Coordinator |  |
| Please state briefly the reason for this assessment |  |

|  |
| --- |
| Has your child been assessed by an educational psychologist, occupational therapist or specialist teacher?  [ ] No [ ] Yes – If yes please briefly give details about their conclusions.  **Please send a copy of any reports at least a week prior to attending for an initial visual assessment.** |
| Has your child undergone any treatment/therapy programme for their learning issues  [ ] No [ ] Yes – If yes please give details of the programme and when/if they completed it. |
| Are they receiving extra help at school?  [ ] No [ ] Yes – If yes please give details on what form this takes. |
| Has your child been awarded any extra time in examinations?  [ ] No [ ] Yes – If yes please give details about who awarded this and how much time was given. |

**Reading Aids**

|  |
| --- |
| Does your child use a reading ruler?  [ ] No [ ] Yes – If yes please give details about how long it has been used for. |
| Does your child use a colour overlay?  [ ] No [ ] Yes – If Yes please give details about what colour is used, who prescribed this and when. |

**Visual History**

|  |
| --- |
| Name and address of optometrist/optician and date of last visit. |
| Were glasses prescribed?  [ ] No [ ] Yes – If yes, please give details about when are they to be worn. |
| Has anyone noticed the eyes turning in or out?  [ ] No [ ] Yes – If yes, please give details about when this was first noticed and how long it lasted. |
| Has your child ever had an eye operation?  [ ] No [ ] Yes – If yes, please give details of what the operation was for and when it was performed. |
| Has your child ever been given eye exercises or patching?  [ ] No [ ] Yes – If yes, please give details of the treatment and at what age it began. |

**Visual Symptoms**

When you are reading or writing do the words ever:

|  |  |
| --- | --- |
| Go blurry | [ ] No [ ] Yes |
| Seem to run together | [ ] No [ ] Yes |
| Jump around | [ ] No [ ] Yes |
| Go smaller or bigger | [ ] No [ ] Yes |
| Fade or disappear | [ ] No [ ] Yes |
| Get faint colours around them | [ ] No [ ] Yes |
| Appear to fall off the page | [ ] No [ ] Yes |
| Seem hidden by the white on the page | [ ] No [ ] Yes |
| See two numbers or words on the paper when you know there is only one | [ ] No [ ] Yes |
| Does reading or writing ever make you cry? | [ ] No [ ] Yes |
| Do your eyes sting or burn after reading for a while? | [ ] No [ ] Yes |
| Do you ever feel you have to cover one eye to help get reading or desk work done? | [ ] No [ ] Yes |
| Do you have to wait for your eyes clear when you look up from reading or desk work | [ ] No [ ] Yes |
| Do you get sore eyes when reading | [ ] No [ ] Yes |
| When you look at the board at school, is it usually quite clear? | [ ] No [ ] Yes |

**Visual Behaviour**

Does your child exhibit any of the following behaviours?

|  |  |
| --- | --- |
| Holding books at arms length | [ ] No [ ] Yes |
| Changing the distance of printed material | [ ] No [ ] Yes |
| Rubbing eyes whilst reading | [ ] No [ ] Yes |
| Screwing the eyes up whilst reading | [ ] No [ ] Yes |
| Frequent or excessive blinking | [ ] No [ ] Yes |
| Moving the head whilst reading | [ ] No [ ] Yes |
| Following text by using a finger or guide to keep place | [ ] No [ ] Yes |
| Reverses letters | [ ] No [ ] Yes |
| Skipping letters | [ ] No [ ] Yes |
| Following text by using a finger or guide to keep place | [ ] No [ ] Yes |
| Skipping words | [ ] No [ ] Yes |
| Skipping lines | [ ] No [ ] Yes |
| Slow at reading | [ ] No [ ] Yes |
| Tires easily | [ ] No [ ] Yes |
| Poor attention span | [ ] No [ ] Yes |
| Disruptive behaviour in class | [ ] No [ ] Yes |
| Poor general co-ordination | [ ] No [ ] Yes |
| Poor handwriting | [ ] No [ ] Yes |
| Sensitive to light | [ ] No [ ] Yes |
| Poor memory of text read | [ ] No [ ] Yes |
| Vocalises when reading silently | [ ] No [ ] Yes |
| Avoids reading where possible | [ ] No [ ] Yes |
| Only reads comics or books with lots of pictures | [ ] No [ ] Yes |
| Fidgets a lot | [ ] No [ ] Yes |

**Developmental History**

|  |  |
| --- | --- |
| Was your child born prematurely?  [ ] No [ ] Yes – If yes, by how many weeks? | |
| Did your child have any difficulties in the following areas | |
| Sitting | [ ] No [ ] Yes |
| Crawling | [ ] No [ ] Yes |
| Walking | [ ] No [ ] Yes |
| Speech | [ ] No [ ] Yes |
| Emotional | [ ] No [ ] Yes |

**Medication and general health**

|  |  |
| --- | --- |
| Has your child been on any regular medication?  [ ] No [ ] Yes – If yes please give details | |
| Please list any operations or severe illness that your child had in the first year of life. | |
| Has you child had any hearing problems? | |
| Has your child had grommets fitted or had recurring ear infections in the first two years of life? | |
| Has your child ever suffered from epilepsy, fits or convulsions? | [ ] No [ ] Yes |
| Does your child have any allergies?  [ ] No [ ] Yes – If Yes please list. | |
| Is your child generally fit and healthy? | [ ] No [ ] Yes |
| Does your child suffer from regular headaches?  [ ] No [ ] Yes – If yes what is your child doing when they occur (e.g. reading, at school, TV, playing etc.) and how often have they occurred in the last two months? (e.g. daily, 3x weekly etc.) | |
| How bad are the headaches usually?  Slight [ ] Mildly Disturbing [ ] Needs pain killers [ ] Requires bed rest [ ] Requires time off School [ ] | |
| Where on the head so they usually occur?  Top [ ] Temple [ ] Forehead [ ] Back [ ] In, around or behind the eyes [ ] | |
| Is the pain:  Sharp [ ] Dull ache [ ] Sharp stabbing [ ] Throbbing [ ] Other [ ] (Please Specifiy) | |
| How long does the pain usually last? | |

**Family Visual History** (please tick the appropriate boxes)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Long sighted | Short Sight | Astigmatism | Amblyopia (lazy eye) | Strabismus (eye turns) | Colour defect | Reading difficulties |
| Parents |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Grandparent |  |  |  |  |  |  |  |
| Uncle/Aunt |  |  |  |  |  |  |  |

Thank you for your help in carefully completing this questionnaire. It will help us to choose the most appropriate tests and examinations for your child when we see him or her, and enable us to spend more time with your child.

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Please feel free to ask the Optometrist any questions you may have.

**CONSENT**

It is often beneficial for us to discuss our examination results with your child’s school and/or other healthcare professionals involved in his or her care. Please sign below to indicate that you authorise this exchange of information and to indicate you have read and understood the conditions attached to vision therapy appointments.

From time to time, we also like to review our procedures and audit our patient records. On occasions, we may use the results for research. When this is done, we NEVER reveal the name or addresses of our patients to any third party. We would be grateful for your consent to use the data from examinations and therapy (if any) to help us, but we need your authority to do so.

I consent to the sharing of information with my child’s school and their professional carers, and to use the data for research and audit purposes. I also confirm that I am aware of and agree to pay the fees charged for vision assessments and any other treatment I agree to undertake.

|  |  |
| --- | --- |
| Signature | Date |
| Print Name | |
| Relationship to child | |