Developmental Evaluation Questionnaire

Has an **IEP or similar school evaluation** been performed? ☐No ☐Yes, by____________________
Were accommodations recommended? ☐No ☐Yes
If yes, please describe the program and results:____________________

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Has a **speech or language evaluation** been performed? ☐No ☐Yes, by____________________
Was speech therapy recommended? ☐No ☐Yes
If yes, please describe the patient age and results:____________________

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Has an **occupational therapy evaluation** been performed? ☐No ☐Yes, by____________________
Was occupational therapy recommended? ☐No ☐Yes
If yes, please describe the patient age and results:____________________

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Has a **neurological or psychological evaluation** been performed? ☐No ☐Yes, by____________________
Please describe the results and recommendations:____________________

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Has a **vision therapy evaluation** been performed? ☐No ☐Yes, by____________________
Was vision therapy recommended? ☐No ☐Yes
If yes, please describe the program and results:____________________

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FAMILY AND HOME

Please indicate which adult(s) he/she lives with? ☐Mother ☐Father ☐Stepmother ☐Stepfather

☐Grandmother ☐Grandfather ☐Other Caretaker____________________

Are there other children at home?____________________

Has your child ever been through a traumatic family situation (such as divorce, parental loss, severe parental illness, separation) ☐No ☐Yes If yes, at what age:____________________

Does your child seem to have adjusted? ☐No ☐Yes

Is family life stable at this time? ☐No ☐Yes

If no, please explain:____________________

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Please give a brief description of your child as a person and add any additional information you feel would be helpful in our treatment of your child.

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Symptom Checklist

Have you or anyone else ever noticed the following? (Check all that apply)

☐Headaches following reading/computer work	☐Reverses letters, numbers or words
☐Eyes hurt or feel tired after close work	☐Difficulty tracking moving objects
☐Feel unusually tired after completing a task	☐Squints, closes, or covers an eye
☐Unusual blinking	☐Unusual posture/head tilt with near work
☐Unusual eye rubbing	☐Avoids near tasks
☐Dry eyes	☐Loses awareness of surroundings when concentrating
☐Watery eyes	☐Motion/car sickness
☐Eyesight blurs at distance when looking up from near work	**Complete this section only if your child is a reader:**
☐Print seems to move or go in and out of focus	☐Skips words while reading/copying
☐Crooked and/or poorly spaced handwriting	☐Loses place while reading/copying
☐Misaligns letters and/or numbers	☐Skips lines while reading/copying
☐Makes errors when copying	☐Rereads words or lines
☐Poor spelling skills	☐Poor reading comprehension
☐Dislikes tasks requiring sustained concentration	☐Holds head too close when reading/writing
☐Confuses right and left directions	☐Letters/lines "run together" or "jump"
☐Restlessness when working at a desk	☐Feels sleepy when reading
☐Poor concentration abilities	☐Uses finger as a marker when reading
☐Unusual clumsiness	☐Reads slowly
☐Difficulty with eye-hand coordination	☐Vocalizes when reading silently
☐Short attention span/loses interest	☐Difficulty recognizing the same word on a different page

Information Regarding Teacher Conferences

Dr. Pierce and Dr. VanNoy are committed to providing the best possible care for your child. Many visual diagnoses can have a direct impact on learning and school performance. Although the doctors will explain this to you in detail during your child's exam, it can be beneficial to discuss these issues with your child's teacher(s) as well. Our doctors would be happy to do this in the form of a phone conference involving the teacher(s), principal, occupational therapist, or any other professional that would be included, for a separate service fee unless your child is enrolled in a therapy program at our office.

If you choose for your doctor to have this conference, you will be notified on the date and time for which it is scheduled.

You have my permission to discuss information obtained from my child's evaluation, including treatment options, with their teacher(s) or other professionals at their school.

____________________________________ ____________________

Parent/Guardian Signature Date