

## 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: \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

Has a **neurological or psychological evaluation** been performed?  No  Yes, by \_\_\_\_\_

Please describe the results and recommendations: \_\_\_\_\_

\_\_\_\_\_

Has a **vision therapy evaluation** been performed?  No  Yes, by \_\_\_\_\_

Was vision therapy recommended?  No  Yes

If yes, please describe the program and results: \_\_\_\_\_

\_\_\_\_\_

### 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: \_\_\_\_\_

\_\_\_\_\_

**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.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Symptom Checklist

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

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