Today's Date:

Visual Perceptual Developmental Questionnaire

Patient's Name: _____ Birthdate: _____

School: _____

Grade:_____ Teacher's Name: _____

Parents' Names: _____

Child lives with: _____

Contact Info

Mom's Cell Number: _____

Mom's Email: _____

Dad's Cell Number: _____

Dad's Email: _____

Referred by: _____

Primary concerns:

Previous treatments for concern:

Date of most recent eye exam with eye dr: _____ (If exact date unknown, what year?)

Result of that eye exam: _____

Does your child wear glasses? _____YES _____No If YES correction is for: _____

_____

Glasses worn since age: _____

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At Home

1. Were there any medical problems during pregnancy? If so, please describe.

2. Was your child delivered at term or early/late?

3. Maternal use of pharmaceutical/over the counter drugs or alcohol? _____YES _____NO
   If YES please describe:

4. Was the birth process unusual in any way? (C-section, forceps, suction, induction, long, short)

5. Birth weight: _____
6. Describe any unusual physical issues? (jaundice, bruising, distorted skull)

7. Did your child start walking early (before 10 months) or late (after 16 months)?
8. Did your child skip the crawling stage? _____YES _____NO
9. Did your child use a non-traditional form of crawling (scooting on bottom, pushing off on one foot, slithering on stomach)? _____YES _____NO If YES please describe:

10. Was your child late learning to talk? _____YES _____NO
11. Developmental Milestones:
    First sat up without support at ____ months
    First walked at _____ months
    First talked at _____ months
    Any developmental delays? _____YES _____NO If YES please describe:

12. Did your child experience any serious illness or seizures in the first 18 months of life?
    _____YES _____NO If YES please describe:

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13. Did your child wet the bed regularly/frequently past the age of 5? _____YES _____NO
14. Does your child suffer from motion sickness? _____YES _____NO
15. Does your child have headaches? _____YES _____NO If YES when do they typically occur?
16. Does your child have recurrent tummy aches? _____YES _____NO If YES when do they typically occur?
17. Did your child have frequent ear infections? _____YES _____NO
18. Childhood Medical History. Describe Infections, chronic illnesses, hospitalizations, trauma, etc:

19. Has your child ever had any head injuries? _____YES _____NO If YES please describe:

20. Did your child have trouble establishing hand dominance or crossing the midline with objects? _____YES _____NO
21. Did your child confuse concepts such as left/right, before/after, above/below, greater/less, etc.? _____YES _____NO

    Family history of learning disabilities or eye problems? _____YES _____NO If YES please describe:

22. Can your child ride a bike without training wheels? _____YES _____NO
23. Can your child easily catch a ball? _____YES _____NO
24. Can your child consistently bat a ball? _____YES _____NO

Is there anything else you'd like us to know?

Today's Date:

At School

1. Educational History: Age at which formal school was initiated? _____

   Functioning on grade level? _____YES _____NO

   Current reading level if known: _____

   List any grades repeated? _____

   Educational setting (mainstream, special ed, gifted, home schooled): _____

   Is English your first language? _____YES _____NO If NO, which language is preferred?

2. Did your child have difficulty learning to read and/or write in the early years of school?

   _____YES _____NO If YES please describe:

3. Has your child had any testing done for learning disabilities, dyslexia, ADD/ADHD, etc?

   _____YES _____NO If YES please describe what testing has been done and note who did the testing (school, medical facility, etc):

4. List any interventions/treatments (visual, psycho educational, audiology, speech, occupational therapy, tutoring, neurological, behavior/attention):

5. Does your child have any diagnoses? _____YES _____NO If YES please describe:

6. Does your child have an IEP or 504 Plan in place? _____YES _____NO If YES please describe what diagnoses are being addressed and what services are being provided:

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7. Did your child have difficulty telling time on an analogue clock? _____YES _____NO
8. Does your child have difficulty or make mistakes when copying from the board?

   _____YES _____NO
9. Does your child have difficulty sitting still in a chair during school? _____YES _____NO
10. Does your child occasionally miss letters or write them backwards? _____YES _____NO
11. Does your child have an awkward pencil grip? _____YES _____NO
12. Has a teacher or other ever suggested that your child may have focus or attention difficulties or ADD/ADHD? _____YES _____NO If YES please describe:

13. If there is sudden noise would your child over-react? _____YES _____NO
14. Screen time during a typical day (including at-school computers/Ipads, cell phone games, video games, TV, etc. Anything with a screen):
15. How many evenings did your child practice reading at home last week? _____
16. Does your child typically have homework? _____YES _____NO If YES please describe:

17. Describe any extra-curricular activities in which your child participates:

Is there anything else you'd like us to know?