Christopher Young Opticians

Vision with Beauty

Please return to Christopher Young Opticians, The Young Clinic, 46 High Street, Shepton Mallet, Somerset BA4 5AS on completion

Pre Assessment Questionnaire

Patient's Full Name..

Home Address...

....postcode..........................

Parent's name (if different)…………………………………………………………………

Home telephone number.................................. Parent's daytime number...............................

E-mail address.. Fax ....

Date and time of assessment .... a.m. / p.m. on..

Date of Birth .... / .... / .... School...

Who referred you to our practice?..

Name and address of G.P..

……………………………………………………………………………………………..

This questionnaire will allow us to plan for your appointment, and will give us much background information about your child. Please fill in as fully as you are able.
It would help to have your child's teacher fill in the questionnaire as well - completing a photocopy or using a different colour to yours!

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Please try to explain your chief concerns that have led to you seeking our help
Please do fill this section in!

Previous Visual History.

Has there been any previous visual care? Yes No

Please describe in detail, including information on any eye tests, glasses, any orthoptic exercises, surgery, patching etc. that may have been used. <u>If you have a copy of the current spectacle prescription, please bring with you to the exam, as well as any glasses.</u>

If spectacles have been prescribed, are they still worn? Yes No

Does your child report any of the following?
(please tick as appropriate, if very common use two ticks)

Visual Signs

	Yes	No
Black/whiteboard is blurred	____	____
Blurred vision when looks from the page to the board	____	____
Words blur or go in and out of focus whilst reading	____	____
Difficulty in copying from blackboards / whiteboards	____	____
Tired eyes when reading or doing close work	____	____
Pain or discomfort around the eyes with close work	____	____
Headaches with reading or close work	____	____
Excessive tiredness after close work	____	____
Reddened eyes or lids	____	____
Eyes sting, burn or sore after reading for a while	____	____
Use finger or bookmark to help keep place	____	____
Print ‘doubling’, ‘running together’ or wobbling about’	____	____
Closing or covering one eye, either when working, or viewing at distance	____	____
One eye turning in, out, up or down at any time	____	____
Reversal of letters or numbers when reading	____	____
Skip over or omit words/lines/letters when reading	____	____
Reads Slowly	____	____
Has trouble remembering what has been read	____	____
Loses concentration easily	____	____
Excessive eye rubbing or blinking	____	____
Frowning, scowling or squinting with visual tasks	____	____
Moving in and out when working (constantly varying working distance)	____	____
Moving very close to work or holding books very close	____	____
Avoids close work	____	____
Prefers comics/books with pictures	____	____

Please give further information if you feel it would be of help

General Signs

	Yes	No
Difficulty with co-ordination	____	____
Problems with balance	____	____
Prone to travel sickness	____	____
Untidy handwriting	____	____

Discomfort in hand when writing	____	____
Letters formed backwards in writing	____	____
Difficulties with spelling	____	____
Spelling errors generally phonetic	____	____
Can learn spellings well for tests	____	____
Fidgets a lot	____	____

Developmental History

Were there any complications during pregnancy, or at birth? (please give details)

Was birth premature?	Did birth involve:- Caesarian Section?	Forceps?
Was birth weight low?	Did child thrive?	Jaundice?

At what age did your child:-

Crawl?............. Was crawling normal?

Walk? ....

Talk? .... Was speech therapy needed? Yes / No Is speech now clear? Yes / No

Hearing.

Have there been any hearing problems? Yes No

If so, please detail, *including which ear was involved (if known)*

Have grommets been used?	Yes	No
Is hearing now reported to be normal?	Yes	No
Does your child respond well to verbal instructions?	Yes	No

Health

Does your child have any health problems? Yes No

If yes, please give details

Does your child suffer from allergies? Yes No

Please give details

Does your child have any nutritional or eating problems? Yes No

If yes, please give details

Family History

Is there any family history of visual problems? Yes No

Please give details...

Is there any family history of dyslexia or learning difficulty? Yes No

Please give details...

Is there any family history of hyperactivity, attention difficulties or speech problems?

Please give details... Yes No

Laterality

Is your child: left handed _______ right handed ___________ ambidextrous ________ ?

Hand dominance in family (indicate **L**eft, **R**ight or **A**mbidextrous)

Father Mother Siblings 1. ___ 2. ___ 3. ___ 4. ___

Does your child confuse directions and lefts and rights? Yes No

Is there similar confusion in the family? Maternal side _____ Paternal side _____

School

Have your child's school expressed any concerns about academic progress?

Is your child receiving extra support either in or out of school? Yes No

Does your child experience difficulties in other subjects apart from English? Yes No
-please give details.

Have there been any behavioural problems? Yes No
If so, please detail:

Have any other tests been carried out (e.g. educational psychological evaluation) Yes No
<u>If yes, please could you let us see a copy of any reports that have been prepared***</u>***

In your opinion, what are your child's:

Best subjects?

Worst subjects?

What are your child's special interests and hobbies?

Does your child enjoy school? Yes No
Are you satisfied with your child's school performance? Yes No
Does your child read as well as peer group in school? Yes No
Does your child read as well as brothers and sisters? Yes No

Are there any other factors, or further information you feel would be of help to us?

It is often beneficial to discuss examination results with other professionals working with your child; please sign below to authorise this exchange of information.

Signature .... date ....

Relation to child ....

Thank you for taking the time to complete this rather lengthy questionnaire, the information given will help us to plan the most appropriate tests to use, and prepare us for your appointment!