Child Symptom Checklist

Demographics

Personal Information

Title	First	Last	MI	Suffix	Nickname

Address:

City: State/ZipCode

Home Phone: Work Phone:

Other Phone: Alerts:

SSN Email

Birthday Occupation

Sex ○ Male ○ Female Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Marital Status Employer/School Name

Primary Doctor Misc/Guardian

Why do you feel your child needs a visual evaluation?

How long has this problem / difficulty been observed?

Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present? ☐ Yes ☐ No

If yes, what?

Has your child reported any of the following:

Headaches	☐ Yes ☐ No	If yes, when?
Blurred vision (focus goes in and out)	☐ Yes ☐ No	If yes, when?
Double vision	☐ Yes ☐ No	If yes, when?
Nausea when doing visual tasks	☐ Yes ☐ No	If yes, when?
Motion / car sickness	☐ Yes ☐ No	If yes, when?
Halos around lights	☐ Yes ☐ No	If yes, when?
Need for bright light	☐ Yes ☐ No	If yes, when?
Need for dim light	☐ Yes ☐ No	If yes, when?
Eyes "hurt" or "tired"	☐ Yes ☐ No	If yes, when?
Eyes itch, burn or tear	☐ Yes ☐ No	If yes, when?
Eyes frequently reddened	☐ Yes ☐ No	If yes, when?
Closing or covering one eye	☐ Yes ☐ No	If yes, when?
Lose place while reading	☐ Yes ☐ No	If yes, when?
Poor reading comprehension	☐ Yes ☐ No	If yes, when?
Difficulty managing attention while reading	☐ Yes ☐ No	If yes, when?
Head tilt when reading or writing	☐ Yes ☐ No	If yes, when?
Avoid reading	☐ Yes ☐ No	If yes, when?
Head close to paper when reading / writing	☐ Yes ☐ No	If yes, when?
Moves head when reading	☐ Yes ☐ No	If yes, when?
Prefers being read to	☐ Yes ☐ No	If yes, when?
Frequent blinking	☐ Yes ☐ No	If yes, when?
Bothered by light	☐ Yes ☐ No	If yes, when?
Confuses letters or words	☐ Yes ☐ No	If yes, when?
Reverses letters or words	☐ Yes ☐ No	If yes, when?
Left/Right confusion	☐ Yes ☐ No	If yes, when?
Skips, rereads or omits words	☐ Yes ☐ No	If yes, when?
Vocalize while reading silently	☐ Yes ☐ No	If yes, when?
Slow reader	☐ Yes ☐ No	If yes, when?
Uses finger as marker	☐ Yes ☐ No	If yes, when?
Writes neatly but slowly	☐ Yes ☐ No	If yes, when?
Writes or prints poorly	☐ Yes ☐ No	

Awkward or immature pencil grip	☐ Yes	☐ No		
Frequent erasures	☐ Yes	☐ No		
Difficulty copying from the chalkboard	☐ Yes	☐ No		
While reading letters / words appear to float around	☐ Yes	☐ No		
Frequent eye rubbing	☐ Yes	☐ No	If yes, when?	
Frequent sties	☐ Yes	☐ No	If yes, when?	
Comprehension decreases over time	☐ Yes	☐ No	If yes, when?	
Does not support paper when writing	☐ Yes	☐ No	If yes, when?	
Tires easily	☐ Yes	☐ No	If yes, when?	
Difficulty recognizing same word on different page	☐ Yes	☐ No	If yes, when?	
Poor word attack skills	☐ Yes	☐ No	If yes, when?	
Difficulty with memory	☐ Yes	☐ No	If yes, when?	
Remembers better what hears than sees	☐ Yes	☐ No	If yes, when?	
Responds better orally than by writing	☐ Yes	☐ No	If yes, when?	
Seems to know material but does poorly on tests	☐ Yes	☐ No	If yes, when?	
Dislikes / avoids near tasks	☐ Yes	☐ No	If yes, when?	
Short attention span / loses interest	☐ Yes	☐ No	If yes, when?	
Poor large motor coordination	☐ Yes	☐ No	If yes, when?	
Poor fine motor coordination	☐ Yes	☐ No	If yes, when?	
Difficulty with scissors / small hand tools	☐ Yes	☐ No	If yes, when?	
Dislikes / avoids sports	☐ Yes	☐ No	If yes, when?	
Difficulty catching / hitting a ball	☐ Yes	☐ No	If yes, when?	

Television Viewing / Leisure Time Activities

	Hours Per Week	Approximate Viewing Distance
Nintendo games, etc		
Television		
Computer Use		

What other activites occupy your childs leisure time?

Are there any activites your child would like to participate in but doesn't?

Please explain:

Developmental History

Full term pregnancy? ☐ Yes ☐ No

Did the mother experience any health problems during the pregnancy? ☐ Yes ☐ No

If yes, please explain:

Normal Birth? ☐ Yes ☐ No

Any complications before, during or immediately following delivery? ☐ Yes ☐ No

If yes, please explain:

Birth weight: Apgar scores @ birth: After 10 minutes:

Were forceps used? ☐ Yes ☐ No

Was there ever any reason for concern over your child's general growth and development? ☐ Yes ☐ No

If yes, why?

Did your child crawl (stomach on floor)? ☐ Yes ☐ No At what age?

Did your child creep (on all fours)? ☐ Yes ☐ No At what age?

If not, describe:

At what age did your child walk?

Was child active? ☐ Yes ☐ No

Speech: First Words: At what age?

Was early speech clear to others? ☐ Yes ☐ No

Is speech clear now? ☐ Yes ☐ No

Visual History

Has your child's vision been previously evaluated? ☐ Yes ☐ No

If so, Doctor's name: Date of last evaluation:

Reason for examination:

Result and recommendations:

Were glasses, contact lenses, or other optical devices recommended? ☐ Yes ☐ No

If yes, what?

Are they used? ☐ Yes ☐ No

If yes, when?

If not used, why not?

Members of the family who have had visual attention and the reason?

Name	Age	Visual Situation

School

Age at time of entrance to: Preschool Kindergarten First Grade

Does your child like school? ☐ Yes ☐ No

Specifically describe any school difficulties:

Has your child changed schools often? ☐ Yes ☐ No

If yes, when?

Has a grade been repeated? ☐ Yes ☐ No

If yes, which and why?

Does you child seem to be under tension or extreme pressure when doing school work? ☐ Yes ☐ No

Has your child had any special tutoring, therapy, and/or remedial assistance? ☐ Yes ☐ No

If yes, when?

Where and from whom?

How long?

Results:

Does your child like to read? ☐ Yes ☐ No

Voluntarily? ☐ Yes ☐ No

Does your child read for pleasure? ☐ Yes ☐ No

What?

What is your child's attitude towards reading, school, his/her teachers, other youngsters?

Overall school work is: ☐ above average ☐ average ☐ below average

Which subjects are:

Above average:

Average:

Below Average:

Does your child need to spend a lot of time/effort to maintain this level of performance? ☐ Yes ☐ No

How much time on average does your child spend each day on homework assignments?

To what extend do you assist your child with homework?

Do you feel your child is achieving up to potential? ☐ Yes ☐ No

Does the teacher feel your child is achieving up to potential? ☐ Yes ☐ No

General Behavior

Are there any behavior problems at school? ☐ Yes ☐ No

If yes, what?

Are there any behavior problems at home? ☐ Yes ☐ No

If yes, what?

What causes these problems?

Child's reaction to fatigue? ☐ sag ☐ irritable ☐ other

Child's reaction to tension? ☐ sag ☐ irritable ☐ other

Does your child say and/or do things impulsively? ☐ Yes ☐ No

Is your child in constant motion? ☐ Yes ☐ No

Can your child sit still for long periods? ☐ Yes ☐ No

Family and Home

Fathers Name: Birth Date:

Address (if different from child's):

Phone:

Business Name: Occupation:

Business Address: Phone:

City: State: ZIP:

Mothers Name: Birth Date:

Address (if different from child's):

Phone:

Business Name: Occupation:

Business Address: Phone:

City: State: ZIP:

Please indicate which adult he/she lives with:

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather

☐ Foster Parents ☐ Adoptive Parents ☐ Grandmother ☐ Grandfather

☐ Aunt ☐ Uncle Other

Does your child spend time with any other person not in the home? ☐ Yes ☐ No

Please explain:

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness? ☐ Yes ☐ No

If yes, at what age?

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

Was counseling / therapy undertaken? ☐ Yes ☐ No

If yes, is it on-going? ☐ Yes ☐ No

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

If no, please explain?

Did father or anyone in fathers family have a learning problem? ☐ Yes ☐ No

If yes, who?

Did mother or anyone in mother's family have a learning problem? ☐ Yes ☐ No

If yes, who?

Do you, or did any of the other children in the family have learning problems? ☐ Yes ☐ No

If yes, who?

To what extent?

Give a brief description of your child as a person:

Is there any other information you feel would be helpful / important in our treatment of your child?

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