*****PARENTS: Please answer the following questions based on your observations or based on symptoms your child has expressed PRIOR to today's evaluation.*****

YES	NO	Accommodative:
____	____	Eyes burn or feel strained after short periods of desk work
____	____	Vision gets blurry when reading
____	____	Complains of headaches or sore eyes when reading
____	____	Fatigues quickly when reading
____	____	Excessive fatigue at end of school day

YES	NO	Binocular:
____	____	Eyes appear to cross in or drift out
____	____	Double vision when reading
____	____	Words run together or move when reading

YES	NO	Oculomotor:
____	____	Often loses place or omits words when reading
____	____	Skips words or lines or has to re-read lines
____	____	Uses finger to keep his/her place when reading
____	____	Difficulty copying from board to book
____	____	Sloppy handwriting, excessive erasures
____	____	Writes crookedly, poorly spaced, or outside the lines

YES	NO	General questions:
____	____	Reverses words, numbers or letters
____	____	My child is having difficulty with reading
____	____	My child has sustained a concussion

Were you referred to our office for an exam? If so, who? (School, teacher, pediatrician, tutor, etc.) ________________________________
____

Do you have any other specific needs or concerns? _______________
____
____
____

Patient Name: ____

Parent/Guardian Name: (please print) ___________________________
Date: ______________________

11/2019