Reading Dysfunction Questionnaire

Confidential

Introduction

Please complete as much of this questionnaire as possible. Don't worry if you cannot answer all the questions. If you are not sure, just leave them blank, and we will discuss any uncertainties with you at the assessment.

Patient's Name……………………………………………………………………Date of Birth……………………………………………..

Date of appointment………

Who referred you to us?...

Please give their address………

Please give your G.P's name and address…………………………………………………………………………………

What school or college to you attend?..

Please state the address……

Please state briefly the reason for this assessment………………………………………………………………….

………

………

Visual History- questions relate to the patient.

Date of last visit to optometrist…………………………………………………………………………………………………..

Name and Address of optometrist (if known)…………………………………………………………………………….

Were you given glasses? Yes ☐ No ☐

If yes, when are they worn?...

Has anyone noticed the eyes turning in or out? Yes ☐ No ☐

If yes, at what age was first noticed, and how long did it last?...

Have you ever had an eye operation? Yes ☐ No ☐

If yes, please give details, if you can, of what the operation was for and when it was performed.

………

Have you ever been given eye exercises or patching? Yes ☐ No ☐

If yes, please give details of the treatment and at what age I was started.

………

………

Visual Symptoms

When you look at the board at school, is it usually quite clear? Yes ☐ No ☐

When you are reading or writing do the words ever:

	Yes	No
Go Blurred	Yes ☐	No ☐
Jump around	Yes ☐	No ☐
Go smaller or bigger	Yes ☐	No ☐
Fade or disappear	Yes ☐	No ☐
Get faint colours around them	Yes ☐	No ☐
Appear to fall off the page	Yes ☐	No ☐
Seem hidden by the white on the page	Yes ☐	No ☐
Wobble on the page	Yes ☐	No ☐
Seem like there are rivers running down the page	Yes ☐	No ☐
Seem like there are two numbers or words on the page when you know there is supposed to be one	Yes ☐	No ☐
Make you cry	Yes ☐	No ☐
Sting or burn after reading for a while	Yes ☐	No ☐
Do you ever feel you have to cover one eye to help get reading or desk work done	Yes ☐	No ☐
Do you have to wait to get your eyes clear when you look up after reading or desk work	Yes ☐	No ☐
Do you get sore eyes after reading for a while	Yes ☐	No ☐
Do you ever find small print is really hard to cope with	Yes ☐	No ☐

Visual Behaviour

	Yes	No
Holding books at arms length	Yes ☐	No ☐
Changing the distance of printed material	Yes ☐	No ☐
Rubbing eyes whilst reading	Yes ☐	No ☐
Screwing the eyes up whilst reading	Yes ☐	No ☐
Frequent excessive blinking	Yes ☐	No ☐
Moving the head whilst reading	Yes ☐	No ☐
Following text whilst using a finger or guide to keep place	Yes ☐	No ☐
Reverses letters	Yes ☐	No ☐
Skipping letters	Yes ☐	No ☐
Skipping Words	Yes ☐	No ☐
Skipping Lines	Yes ☐	No ☐
Slow at reading	Yes ☐	No ☐
Tires easily	Yes ☐	No ☐
Poor attention span	Yes ☐	No ☐
Disruptive behaviour in class	Yes ☐	No ☐

Poor general co-ordination Yes ☐ No ☐

Poor handwriting Yes ☐ No ☐

Sensitive to light Yes ☐ No ☐

Poor memory of text read Yes ☐ No ☐

Vocalises when reading silently Yes ☐ No ☐

Visual Habits

Avoids reading where possible Yes ☐ No ☐

Only reads comics or books with lots of pictures Yes ☐ No ☐

Moves books around when reading Yes ☐ No ☐

Fidgets a lot Yes ☐ No ☐

Birth History

Was labour induced Yes ☐ No ☐

How long did labour last?..................................Hours

Was the delivery normal? Yes ☐ No ☐ Caesarian Yes ☐ No ☐ Forceps or instrument Yes ☐ No ☐

Were there any problems during delivery? Yes ☐ No ☐. If yes, please explain briefly:

…….

Birth weight……………………………

After birth was this child:-

- In need of medical attention? Yes ☐ No ☐
- Given oxygen? Yes ☐ No ☐
- Taken to special care? Yes ☐ No ☐
- Other (please specify)………

Was the birth prematurs? Yes ☐ No ☐ If yes, how long was the pregnancy?....................................

Developmental History

Does this child have difficulties in the following areas? **Sitting** Yes ☐ No ☐, **Crawling** Yes ☐ No ☐

Walking Yes ☐ No ☐, **Speech** Yes ☐ No ☐, **Emotional** Yes ☐ No ☐

Medication & General Health

Has your child been on any regular medication? Yes ☐ No ☐

If yes, please give details……

Please list any operations or severe illness that your child has had in the first year of life……………………

………

Has your child ever suffered from epilepsy, fits or convulsions? Yes ☐ No ☐

Is your child generally fit and healthy? Yes ☐ No ☐

Family Visual History (please tick appropriate boxes)

	Long sighted	Short sighted	Astigmatism	Amblyopia (lazy eye)	Strabismus (eye turns)	Colour defect	Other (please specify)
Parents							
Siblings							
Uncle/Aunt							
Grandparent							

General Family History

Has anyone in the family experienced difficulties in reading? Yes ☐ No ☐

If yes, who?...

Headaches

Does your child suffer from headaches? Yes ☐ No ☐

If yes, how often have they occurred in the last 2 months? (e.g. daily, 3x per week etc.)………………………

What is the child doing when the headaches occur? (e.g. reading, at school, TV, playing etc.)……………….

………

How bad are the headaches usually? (Please circle relevant answer)

Slight / Mildly disturbing / needs painkillers / needs to go to bed / Has to take time off school

Where on the head do they usually occur?

Top / Temple / Forehead / Back / In, around or behind the eyes

Is the pain:

Sharp / Dull ache / Sharp stabbing / Throbbing / Other (please specify)…………………………………………………

How long does the pain normally last?...

Thank you for your help in completing this questionnaire. It will help us choose the most appropriate tests and examinations for your child when we see him or her, and enable us to spend more time with your child.

Please feel free to ask the optometrist any questions you may have.

Consent

It is often beneficial for us to discuss our examination results with your child's school and/or other healthcare professionals involved in his or her care. Please sign below to indicate that you authorise this exchange of information and to indicate that you have read and understood the conditions attached to vision therapy appointments.

From time to time, we also like to review our procedures and audit our patient records. On occasions, we may use the results for research. When this is done, we NEVER reveal the names or addresses of our clients to ANY third party. We would be grateful for your consent to use the data from examinations and therapy (if any) to help us, but we need your authority to do so.

I consent to sharing information with schools and professional carers and to use of the data for research and audit purposes.

Signature……………………………………………………………………………………Date………………………………………………

Print name and initials…………………………………………………..Relationship to child…………………………………..

For children over 12 years of age and older.

In order to comply with the data protection laws, children aged 12 years and over have the right to object to us using information about them – even if their parents agree. If you are 12 years or older and you agree that we can use the information we have about you as described above, please sign below. Thank you.

Signature……………………………………………………………………………Date……………………………………………………..

Print name and initials………………………………………………………………………

Witness signature…………………………………………………………………Date…………………………………………………………

Print name and initials please…………………………………………………………..