

CHILDREN'S QUESTIONNAIRE

Name: _____ Male/Female: ____ Age: ____

Address: _____ P/code: _____

Ph: _____ School: _____ Year: _____

Date of Birth: _____ Your relationship to the child: Parent / Teacher Date: _____

General Indicators (Please circle)

While reading does s/he:

- | | Often | S/times | Rarely | Never |
|--|-------|---------|--------|-------|
| 1. Skip words and/or lines? | O | S | R | N |
| 2. Lose his/her place? | O | S | R | N |
| 3. Re-read lines? | O | S | R | N |
| 4. Use his/her finger <u>or</u> a ruler as a marker? | O | S | R | N |
| 5. Not notice the full stops and commas? | O | S | R | N |
| 6. Read slowly and hesitantly / word by word? | O | S | R | N |
| 7. Become fidgety or restless? | O | S | R | N |
| 8. Become easily distracted? | O | S | R | N |
| 9. Read better on some days than others? | O | S | R | N |
| 10. Have difficulty with comprehension? | O | S | R | N |
| 11. Would you describe his/her reading fluency as erratic? | O | S | R | N |

Does s/he:

- | | | | | |
|--|---|---|---|---|
| 12. Avoid reading whenever possible? | O | S | R | N |
| 13. Avoid writing tasks? | O | S | R | N |
| 14. Find spelling difficult? | O | S | R | N |
| 15. Daydream in class? | O | S | R | N |
| 16. Seem hyperactive <u>or</u> easily distracted? | O | S | R | N |
| 17. Lose his/her place when copying from the board, a book and/or computer? | O | S | R | N |
| 18. Make errors while copying from the board, a book and/or computer? | O | S | R | N |
| 19. Make errors in mathematical calculations by placing answers or numbers in the wrong columns? | O | S | R | N |

Visual Resolution

- | | Often | S/times | Rarely | Never |
|---|-------|---------|--------|-------|
| 20. When reading do words look blurry or fuzzy? | O | S | R | N |
| 21. Is reading hard because words double, move or look funny? | O | S | R | N |
| 22. Do you blink, squint or open eyes wider to help see the words better? | O | S | R | N |
| 23. Does he/she confuse: <u>letters</u> - b/d , p/q, i/l or o/c/a ? | O | S | R | N |
| : <u>words</u> - was/saw, on/no, for/of/from, the/and? | O | S | R | N |
| : <u>numbers</u> - 37 = 73, 249 = 294 | O | S | R | N |

Eye Strain / Fatigue

While reading does s/he:

Often S/times Rarely Never

- | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 24. Complain of eye strain? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. Say his/her eyes: hurt <input type="radio"/> burn <input type="radio"/> itch <input type="radio"/> water <input type="radio"/> feel dry <input type="radio"/> feel sleepy <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. Rub his/her eyes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. Move closer to the page? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. Move away from the page? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. Move his/her head <u>or</u> body side to side while reading across lines of text? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. Read from an awkward angle / tilt his/her head / close one eye? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 31. After reading or book work do his/her eyes look red or watery? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 32. Does s/he complain of headaches at the end of the school day? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 33. Does s/he feel exhausted <u>or</u> want to have a sleep after school? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 34. When watching television <u>or</u> on the computer do his/her eyes: hurt <input type="radio"/> burn <input type="radio"/> strain <input type="radio"/> water <input type="radio"/> tire <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Photophobia (Light Sensitivity)

Does s/he:

Often S/times Rarely Never

- | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 35. Prefer to read in dull light or in a darker part of the room? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 36. Shade the page when reading? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 37. Find computer screens, white boards, Smart Boards bright or glary? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 38. Squint when outside, complain about the light, likes to wear a hat? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Depth Perception

Does s/he:

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 39. Have messy or untidy writing? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 40. Have difficulty cutting on a straight line? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 41. Seem clumsy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 42. Trip on stairs / spill drinks / have difficulty tying shoelaces? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 43. Veer into you when walking beside them? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 44. Have difficulty catching a tennis ball on the full? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Family History

Yes No

- | | | |
|--|-----------------------|-----------------------|
| 45. Does anyone in the family: (a) avoid reading? | <input type="radio"/> | <input type="radio"/> |
| (b) suffer with eyestrain when reading? | <input type="radio"/> | <input type="radio"/> |
| (c) read slowly? | <input type="radio"/> | <input type="radio"/> |
| 46. Did anyone in the family drop out of school, have a learning problem <u>or</u> dyslexia? | <input type="radio"/> | <input type="radio"/> |
| 47. Is anyone in the family light sensitive, bothered by sunlight/glare <u>or</u> must wear sunglasses or a hat? | <input type="radio"/> | <input type="radio"/> |

PLEASE BRING THIS COMPLETED QUESTIONNAIRE TO THIS APPOINTMENT