

BEHAVIORAL VISION, LTD.

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CRYSTAL LAKE

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WHEATON

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VISION SCREENING

Patient's Name: _____ Nickname: _____

Age: _____ Parent's Name: _____ Email: _____

Referred by: _____

As part of the vision screening, we need to know how your child is doing in school.
Please check the areas that apply to your child:

- | | |
|--|--|
| <input type="checkbox"/> Average reader | <input type="checkbox"/> Regular classroom |
| <input type="checkbox"/> Slow/fast reader | <input type="checkbox"/> Special Education |
| <input type="checkbox"/> Doesn't enjoy reading | <input type="checkbox"/> Resource room |
| <input type="checkbox"/> Prefers to be read to | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Poor reading comprehension | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Poor writing skills | <input type="checkbox"/> Repeated grade _____ |
| <input type="checkbox"/> Poor handwriting skills | <input type="checkbox"/> Tutor _____ |
| <input type="checkbox"/> Has letter/number reversals | <input type="checkbox"/> Title I reading |
| <input type="checkbox"/> Homework takes longer than it should | <input type="checkbox"/> Fatigues, frustrated or stressed |
| <input type="checkbox"/> Struggles in school | <input type="checkbox"/> Omits, inserts or rereads letters and words |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Has difficulty copying from the chalkboard |
| <input type="checkbox"/> Inconsistent or poor sports performance | <input type="checkbox"/> Difficulty spelling |
| <input type="checkbox"/> Fine or gross motor skill difficulties | <input type="checkbox"/> Difficulty estimating size and distance |
| <input type="checkbox"/> Avoids tasks that involve reading | <input type="checkbox"/> Knocks over objects on a table |
| <input type="checkbox"/> Displays awkwardness and/or clumsiness | Other concerns: |
| <input type="checkbox"/> Confuses similar looking words | _____ |
| <input type="checkbox"/> Misaligns numbers | _____ |
| <input type="checkbox"/> Writes up or down on a slant | _____ |
| <input type="checkbox"/> Complains of blurred vision | _____ |
| <input type="checkbox"/> Needs to move when reading | _____ |
| <input type="checkbox"/> Significant drop in grades in one year | _____ |
| <input type="checkbox"/> Told that he or she has a learning disability | _____ |
| <input type="checkbox"/> Has headaches, nausea or dizziness when reading | |
| <input type="checkbox"/> Honors curriculum | |

I understand that this is a screening and it does not replace a full vision examination or developmental vision evaluation.