Pre-Assessment Questionnaire (<18)

DATE	
NAME & SURNAME	
REFERRED BY	
SCHOOL & GRADE	

OPTOMETRIST'S NOTES

Please tick ✔ any symptoms and statements that apply to your child.

OCULAR HISTORY		Optometrist's Notes
Currently wearing glasses or contact lenses		
History of eye problems / glasses in the family		
Previous visual therapy or patching		
Previous eye surgery		
VISUAL CONCERNS		
Blurred vision		
One eye turns in or out		
Holds reading material close		
Regular headaches		
Frequently red eyes		
Frequent blinking or rubbing of eyes		
Frequent tilting/turning of the head		
EDUCATIONAL CONCERNS		
History of learning / reading difficulties		
Poor handwriting		
Reversals of letters or numbers		
Difficulty finishing work on time		
Poor concentration and / or hyperactivity		
Poor posture when doing desk activities		
Avoids close work		
SENSORY & PROCESSING		
Poor eye contact		
Sensory sensitive		
Frequently overwhelmed / anxious		
Motion sensitivity / car sickness		
Current / previous developmental support	❍ Occupational therapy ❍ Speech therapy ❍ Educational Psychology	

REPORT

Please indicate with a ✔ if you require a report upon completion of the vision assessment.		
No report required		E-mail
Summary Report		
Comprehensive Report*		

* Please note: Comprehensive reports are charged at R250.00 and can take up to 2 weeks to complete.