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Behavioral Vision
The Vision To Succeed
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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:

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

Other concerns:

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