PRE-SCREENING QUESTIONNAIRE

Name_____ Date of Birth_____ ☐ Male ☐ Female
Last First MI

Address_____ City _____ State_____ Zip_____

Father's Name_____ Father's Cell_____ Father's Email_____

Mother's Name_____ Mother's Cell _____ Mother's Email _____

Home Phone _____

School _____Grade _____ Teacher _____

Insurance _____Vision Company _____

_____Major Medical Company _____

Whom may we thank for referring you to us? _____

General History

Give a brief statement of the primary reason for today's screening._____

_____

Academic History

Indicate any problems in the following areas:

- ☐ Reading
- ☐ Writing
- ☐ Math
- ☐ Spelling
- ☐ Overly Active
- ☐ Comprehension
- ☐ Avoidance of school work
- ☐ Works too hard on school work
- ☐ Slow work
- ☐ Motivation/behavior
- ☐ Reversals of letter or words
- ☐ Loses place/skips lines
- ☐ Poor Memory
- ☐ Attention/Concentration
- ☐ Low Self-Esteem
- ☐ Other _____

Is the child achieving at expected school levels? ☐ Yes ☐ No

Type of Classroom:

- ☐ Mainstream for all subjects
- ☐ Special classroom for all subjects: explain _____
- ☐ Special classroom for some subjects: explain _____

Is the child receiving any help outside of school for the above problems? ☐ Yes ☐ No

If yes, explain _____

Has the child ever repeated a grade? ☐ Yes ☐ No If yes, explain_____

Medical History

Birth was ☐ Premature? ☐ On time? ☐ Late? Birth weight _____

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No If yes, explain _____

_____

List all major health problems to date: _____

_____

List all medications currently being taken: _____

List any allergies: _____

Indicate problem areas:

☐ Headaches:

Location on head _____ Onset - time of day_____

How long do they last? _____

Type of pain: ☐ sharp ☐ dull ☐ throbbing ☐ other:_____

What helps relieve the pain? _____

Is there a history of migraine headaches in the family? ☐ Yes ☐ No

If yes, explain _____

☐ Speech or Hearing: explain _____

Head or eye injury? ☐ Yes ☐ No If yes, explain _____

Visual History

Date of last vision exam: _____

The patient currently wears: ☐ eyeglasses: date prescribed _____
☐ contact lenses: date prescribed _____

Indicate problem areas:

☐ Blur at far	☐ amblyopia (lazy eye)	☐ headaches/fatigue	☐ eye strain
☐ Blur at near	☐ eye-hand coordination	☐ eye alignment	☐ double vision
☐ astigmatism	☐ depth perception	☐ excessive blinking	☐ color vision

Eye surgery? ☐ Yes ☐ No If yes, explain _____

List any current or previous therapy: _____

Would you like a copy of the screening results sent to the child's teacher? ☐ Yes ☐ No
Name: _____ Address: _____

Would you like a copy of the screening results sent to the child's physician? ☐ Yes ☐ No
Name: _____ Address: _____

Learning and Behavior Rating Scale

Please read each of the following statements and rate this child according to the following scale. Place your rating number in the provided space to the right of each statement. Be sure to rate every item.

COMPARED TO OTHER CHILDREN OF THE SAME AGE AND GENDER, THIS BEHAVIOR:

(0) Occurs less often OR the question doesn't apply to the age of the child
(1) Occurs at about the same frequency
(2) Occurs slightly more
(3) Occurs considerably more
(4) Occurs very significantly more

1.	Is careless		33.	Shows poor reading comprehension	
2.	Fidgets or squirms		34	Worries about future events	
3.	Swears or uses obscene language		35.	Is depressed or irritable	
4.	Often asks to have things repeated		36.	Has poor handwriting	
5.	Has difficulty maintaining attention		37.	Has poor spelling skills	
6.	Overreacts		38.	Worries about past behaviors	
7.	Loses temper		39.	Has poor appetite or overeats	
8.	Has poor study and work habits		40.	Squints, blinks or rubs eyes when reading	
9.	Has difficulty organizing activities		41.	Has poor math skills	
10.	Leaves seat in class		42.	Is concerned about what others will think	
11.	Argues with adults		43	Has trouble getting to sleep or sleeps too much	
12.	Reverses letters or words		44.	Has difficulty hearing	
13.	Fails to follow through on tasks		45.	Makes grammatical errors	
14.	Runs or climbs excessively		46.	Is overly concerned about him/herself	
15.	Refuses adults requests or rules		47.	Has little energy and is easily tired	
16.	Feels school work is too hard		48.	Has poor coordination	
17.	Takes a long time to complete tasks		49.	Has poor grades	
18.	Has difficulty playing quietly		50.	Needs reassurance in many areas of life	
19.	Deliberately does things that annoys others		51.	Has low self-esteem	
20.	Does not complete school assignments		52.	Has speech difficulties	
21.	Avoids prolonged mental effort		53.	Receives low test scores	
22.	Answers questions before they are completed		54.	Complains about physical discomforts	
23.	Blames others for mistakes		55.	Feels hopeless	
24.	Has difficulty remembering		56.	Complains about eye strain or fatigue	
25.	Is distracted by other activities		57.	Has difficulty writing a paper	
26.	Has difficulty waiting for turn		58.	Appears tense or unable to relax	
27.	Is angry and resentful		59.	Has poor concentration	
28.	Has difficulty reading or spelling phonetically		60.	Is bothered by loud sounds	
29.	Does not listen		61.	Has poor oral reading	
30.	Is touchy or easily annoyed by others		62.	Fears taking tests	
31.	Holds grudges and seeks revenge		63.	Prefers to be alone	
32	Has difficulty with abstract concepts and reasoning		64.	Skips words or lines when reading	

Please use this space for any comments regarding your child's academic performance, including any additional help and/or support services.