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| --- | --- | --- |
|  | **Questions on eye and vision history**  | **Comments and notes**  |
| 1 | Has your child any history of visual difficulties / problems with sight / visual impairment?  |  |
| 2 | When did your child last have a sight-test by an optometrist (“optician”)?  |   |
| 3 | Was any prescription made? **YES / NO** If **YES**, was your child advised to wear the prescription glasses/contact lenses for **distance** (e.g. for watching television or for driving), **near** (e.g. for reading) **or both**? If **YES**, does your child wear the prescribed glasses / contact lenses? **YES / NO** If **NO**, why not?  |  |
| 4 | If **YES,** does your child have the prescribed glasses/contact lenses with them today?  | Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for distance use only.  |
| 5 | Has your child ever used coloured overlays / colour-tinted glasses? **YES/NO**  If **YES**, who advised and provided them? Why were they recommended? Did they help? If **YES**, in what way? Does your child still use them? If not, why not?  |  |
| **Questions on reading / near work activity**  |
| 6 | Approximately how many hours per school day does your child spend at a screen (phone, tablet, computer) etc?  |  |
| 7 | Approximately how many additional hours per school day does your child spend reading books, newspapers, comics or other paper-based texts?  |  |
| 8 | Has your child's screen /reading /near work time increased recently? If so, by how much?  |  |

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|  |  **Visual Difficulties Questionnaire (pre - 16 years)\***  | Never | Rarely | Sometimes | Often | Always |
| 1  | Does your child report headaches when they are reading?  |  |  |  |  |  |
| 2  | Does your child report that reading makes their eyes feel sore, gritty or watery? |  |  |  |  |  |
| 3  | Does your child report feeling tired or sleepy during or after reading? |  |  |  |  |  |
| 4  | Have you noticed your child become restless, fidgety or distracted when reading?  |  |  |  |  |  |
| 5  | Have you noticed your child rubbing their eyes when they are reading? |  |  |  |  |  |
| 6  | Have you noticed your child screwing up their eyes when reading? |  |  |  |  |  |
| 7  | Have you noticed your child tilting their head to one side when reading? |  |  |  |  |  |
| 8  | Have you noticed your child moving their eyes around or blinking frequently when they are reading?  |  |  |  |  |  |
| 9 | Have you noticed your child holding a paper or book very close to their eyes when reading? |  |  |  |  |  |
| 10 | How often does your child use a marker or their finger to keep their place when reading?  |  |  |  |  |  |
| 11 | Have you noticed that your child frequently loses their place when reading? |  |  |  |  |  |
| 12 | Have you noticed your child covering or closing one eye when reading?  |  |  |  |  |  |
| **Section for child:** |
| 13 | When you read, do you see two of each word?  |  |  |  |  |  |
| 14 | When you read, do the words you read look blurry (or fuzzy, or unclear)?  |  |  |  |  |  |
| 15  | When you are reading, do the words move on the page? |  |  |  |  |  |
| 16  | When your teachers ask you to copy something from a screen at the front of the classroom, can you see what is written on the screen? |  |  |  |  |  |
| **\*N.B. Response categories for this protocol: Always = every day. Often = several times a week but not necessarily every day. Sometimes = 2-3 times a month. Rarely = only once every few months / a year.** |