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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.** | | | | | | |