PARENT INTERVIEW

Student: _____ Date: _____

1. What is the cause of your child's visual impairment?

2. What medications is your child currently taking?

3. Does your child display any unusual visual behaviors? (e.g., eye poking, spinning/twirling objects, light gazing)?

4. What kind of things does your child appear to see?

5. Have you noticed a change in your child's vision recently?

6. What things does your child look at most consistently?

7. Does your child prefer one color over other colors?

8. Are there times of the day (or night) when your child's vision seems better than at other times?

9. Does your child appear to use a head tilt to look at things?

10. Does your child bring objects closer to look at them? How close?

11. How does your child use vision to move through the home?

12. How does your child use vision to move through outdoor environments?

13. Does your child use a cane for travel?

14. Does your child wear glasses or contacts, or use low vision devices?

    a. Consistently?
    b. For near viewing? What tasks?
    c. For distance viewing? What tasks?

15. When was this prescription for glasses or contacts filled?

16. What kind of lighting does your child prefer?

17. What are your major concerns about your child's vision?

18. What does your child like and not like to do?

19. What would you like to see your child do?

20. What are your hopes for your child's future?

21. What else would you like me to know about your child?

Also see *Identification of Potential Visual Problems* document on pages 3 - 5 for more specific issues.