Reading and Learning Questionnaire

Name	Age	Grade	Date

Your responses will help the doctor better understand your child, and address any concerns you may have in areas that could have a visual connection. Please respond to these questions using the following rating system.

0 = Never **1** = Seldom **2** = Occasionally **3** = Frequently **4** = Always

1. I have concerns about my child's reading abilities.

   0 1 2 3 4

2. When reading, my child will skip lines or words.

   0 1 2 3 4

3. There are battles over homework.

   0 1 2 3 4

4. My child needs extra time to complete assignments or tests.

   0 1 2 3 4

5. When writing, my child reverses letters and numbers.

   0 1 2 3 4

6. My child has trouble with attention and concentration.

   0 1 2 3 4