Visual and behavioral profiles of socially 'at-risk' juveniles

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Abstract
The aim of this investigation is to examine the prevalence of visual dysfunction, behavior problems, and co-existing conditions between the two in the socially "at-risk" juvenile population. A sample of 70 socially "at risk" juveniles was drawn from alternative classrooms in the public schools and a training facility for boys. A visual screening battery was administered on-site at each of the three facilities. The screening consisted of: acuity measurement, static retinoscopy, cover test, near point of convergence, stereo acuity, accommodative facility, mobility (DEM), visual-motor perception (Beery), and direct ophthalmoscopy. Behavior profiles were assessed by the classroom teacher utilizing the Child Behavior Check List (Achenbach). "Failure" was designated as any "clinical" score. All 70 subjects failed some area of visual function ranging from 0% in ocular disease to 70% in visual-motor perception to 71% in refractive problems. All subjects displayed some sort of clinically significant behavior problem ranging from 4% in somatic complaints to 27% who measured anxious/depressed. Co-existing conditions with 'fail' scores that were 20% congruent for boys were: refractive status: withdrawn/depressed; visual motor perception: anxious/depressed. Co-existing conditions with 'fail' scores that were 20% congruent for girls were: refractive status: delinquent behavior; accommodative facility: thought problems, attention problems, delinquent behavior; Visual motor perception: delinquent behavior. It was found that juveniles from alternative classrooms exhibit a high prevalence of visual dysfunction along with certain behavior problems. This study suggests that certain visual dysfunction might be viewed as relative risk factors in these behavior problems. No conclusion can be drawn as to cause and effect. However, one is tempted to speculate that juveniles with visual dysfunction will do less well meeting academic demands and hence become prime targets for alternative education.

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Willard B. Bleything

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Visual and Behavioral Profiles
of Socially 'At-Risk' Juveniles

By
SONIA KIM CHUNG
KRISTIN LYNN LIFFICK

A thesis submitted to the faculty of the
College of Optometry
Pacific University
Forest Grove, Oregon
for the degree of
Doctor of Optometry
May 2000

Advisor:
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DISTINGUISHED UNIVERSITY PROFESSOR OF PUBLIC HEALTH AND OPTOMETRY
DISTINGUISHED UNIVERSITY PROFESSOR OF PUBLIC HEALTH AND OPTOMETRY
Sonia Kim Chung graduated cum laude from Boston University with a B.A. in psychology with a minor in biology. She will graduate from Pacific University with a Doctorate of Optometry and a Masters in Education of Visual Function in Learning in May of 2001. She plans to move to Arizona and work in a vision therapy practice.

Kristin Liffick graduated from the University of Washington with a honors level B.A. in art history. She will graduate from Pacific University with a Doctorate of Optometry in May of 2001. She plans to return to the Seattle area and work in a vision therapy practice emphasizing childhood development.
**Abstract:**

The aim of this investigation is to examine the prevalence of visual dysfunction, behavior problems, and co-existing conditions between the two in the socially “at-risk” juvenile population. A sample of 70 socially "at-risk" juveniles was drawn from alternative classrooms in the public schools and a training facility for boys. A visual screening battery was administered on-site at each of the three facilities. The screening consisted of: acuity measurement, static retinoscopy, cover test, near point of convergence, stereo acuity, accommodative facility, mobility (DEM), visual-motor perception (Beery), and direct ophthalmoscopy. Behavior profiles were assessed by the classroom teacher utilizing the Child Behavior Check List (Achenbach). "Failure" was designated as any "clinical" score.

All 70 subjects failed some area of visual function ranging from 0% in ocular disease to 70% in visual-motor perception to 71% in refractive problems. All subjects displayed some sort of clinically significant behavior problem ranging from 4% in somatic complaints to 27% who measured anxious/depressed. Co-existing conditions with 'fail' scores that were 20% congruent for boys were: refractive status: withdrawn/depressed; visual motor perception: anxious/depressed. Co-existing conditions with 'fail' scores that were 20% congruent for girls were: refractive status: delinquent behavior; accommodative facility: thought problems, attention problems, delinquent behavior; Visual motor perception: delinquent behavior.

It was found that juveniles from alternative classrooms exhibit a high prevalence of visual dysfunction along with certain behavior problems. This study suggests that certain visual dysfunction might be viewed as relative risk factors in these behavior problems. No conclusion can be drawn as to cause and effect. However, one is tempted to speculate that juveniles with visual dysfunction will do less well meeting academic demands and hence become prime targets for alternative education.
We thank Beta Sigma Kappa for the generous financial support it gave to our research project. In addition, we greatly appreciate and thank the volunteers who helped us perform our vision screenings. Our classmates generously donated time out of their hectic lives to help us complete the screenings. In addition, our thanks to the administration and classroom teachers of several schools who allowed us to visit their classrooms and spent additional hours completing paperwork to make this project happen. Finally, we give our warmest thank you to Dr. Willard B. Bleything. He has supplied us with many hours of his time, unflagging support, and friendship.
Introduction

Conduct disorders have been a problem for educators for many years. Disruptive children in the classroom lose the full benefits of the educational process, pose a distraction for other children, and lessen the effectiveness of the teacher's efforts. What seems simple 'disruptive classroom behavior' problem in the early grades sometimes becomes a major problem as the child progresses through the school system. For example, research studies have established that disruptive behavior as early as the first grade is a reliable predictor of juvenile delinquency when children enter their teens.1 There is also substantial data showing the association between learning disabilities and juvenile delinquency.2-13 These studies indicate that 80-90% of the juvenile delinquent population is learning disabled and are behind in reading by 4-5 grade levels. So, research has shown a strong correlation that disruptive behavior in the first grade puts a child at particular risk for anti-social behavior as a teen-ager, and that juvenile delinquents are often also learning disabled.

Research has also established that the juvenile delinquent population has a high prevalence of health problems, including a variety of visual dysfunctions.14-25 Most recent studies indicate the prevalence of vision disorders in the juvenile delinquent population to be as high as 62%.26 Problems are particularly evident in eye movement and near focusing skills, as well as two-eyed coordination. All of these visual skills are essential for meeting the demands of the classroom. When visual dysfunctions are present, the child is not fully equipped to benefit from classroom instruction.

There is a strong literature base to indicate the relationship between visual dysfunction and learning disabilities.27-33 Problems particularly evident in the learning disabled population are poor eye movement skills, near focusing problems and difficulty with two-eyed coordination.
It is, therefore, no coincidence that the visual profile of the learning disabled (LD) child matches that of the juvenile delinquent. However, caution is appropriate in developing this argument. Clearly, not all LD children turn out to be juvenile delinquents. However, it can be extrapolated that LD children have a greater risk of becoming juvenile delinquents due to their visual profile.

In summary, research has shown three clear associations: vision disorders and juvenile delinquency, vision disorders and learning disabilities, and learning disorders and juvenile delinquency. The question this research attempts to answer is "Do children with disruptive behavior in early grades have a higher than normal prevalence of visual dysfunction?" The theoretical model is that children who must depend upon a poorly functioning visual system have difficulty meeting the demands of the classroom and act out their frustration in the form of disruptive behavior. The aim of this study, then, is to examine the hypothesis that there is an association between disruptive classroom behavior in middle school age "at risk" students and visual dysfunction.

The Child Behavior Checklist, an extensive behavioral assessment battery, is frequently used by educators to assess school age children. This battery was utilized to gauge the specific behavioral traits of our subject pool. Our hypothesis is children identified as having behavioral problems by the Child Behavior Checklist will also score poorly on a battery of visual tests.

If, indeed, it is determined there to be an association between disruptive behavior and visual dysfunction, a process can be considered for early identification of these children. Early identification will ultimately serve to maximize the learning opportunities for these children and consequently remove a potential risk factor for more serious anti-social behavior.
Method and procedures:

Our study was performed on juveniles from Oregon during a 3 month period between March and May 2000. Three sites were chosen; one rural, one in suburbia, and one in a treatment facility for boys with behavior problems. Three main examiners conducted the study with the help of 15 second and third-year optometry students from Pacific University College of Optometry. All visual testing was done on-site at the schools in conference rooms or classrooms. Equipment and forms were furnished by Pacific University College of Optometry. The subjects were screened for refractive, binocular vision, perception, motility, and ocular disease disorders utilizing a detailed, specific list of pass/fail criteria. The following tests were performed:

- Sharpness of vision far and near (visual acuity)

  A standard Snellen lighted acuity box was used to measure distance acuity. The acuity box stand was placed 6 meters from the subject, and the subject sat in a chair as he/she called off the letters. The near acuity was measured with the reduced Snellen acuity chart, at a measured distance of 40 centimeters with a near lamp illuminating the chart.

- Refractive Status (Static retinoscopy)

  Free space static retinoscopy was performed in a darkened room, with the participant sitting in a chair, looking at the Snellen acuity light box at 6 meters, wearing glasses that compensated for the working distance of the scoper. Free lenses from a standardized lens kit were used to neutralize the reflex. Each examiner had at least two years of experience.
Eye movements (ocular motility)

Range of motility was tested with a standard 1 millimeter colored bead attached to a 10 centimeter clear wand. Each participant was asked to follow the bead, which was moved in front of him/her at a standard speed. Subjective evaluations were made by the examiner in reference to the amount of supportive head movement and the accuracy to which the movements were done. Motility was also assessed with the Developmental Eye Movement (DEM) Test.

DEM

Participants were tested at a well lit table on an individual basis. Each individual was told to read the vertical and horizontal columns as quickly as possible without making mistakes. Test times were recorded using hand held stopwatches. All tests were scored according to the DEM instruction booklet by one of the principal investigators.

Two-eyed coordination (cover test, near point of convergence, stereo acuity)

Cover test was performed at both distance (6 meters) and near (40 centimeters). The cover-uncover was done first, followed by the alternate cover test, and finishing with the cover-uncover test. The subject either looked at a letter on the Snellen acuity box standing 6 meters away, or at a bead 40 centimeters away.

Near point of convergence

Near point of convergence was tested using the same standard 1 millimeter bead. The bead was placed at eye level directly in front of the subject, starting at 50 centimeters. It was
slowly moved towards the nose until the subject reported seeing the bead double, or the examiner saw a breakdown of binocularity.

-Stereopsis

Stereo acuity was tested using the Wirt circles and the Stereo butterfly. The participant wore Polaroid glasses, while observing the Randot tests at 40cm, with standard illumination.

-Near-far focusing ability (accommodative facility)

Accommodative facility was measured with + 2.001-2.00 diopter flippers. The subject was asked to clear the 6M paragraph of the Donder’s nearpoint card, which was held at 40 centimeters with standard near illumination, with the (+) side of the flipper held before the student first. The number of cleared cycles (+ and – is one cycle) was counted over a duration of two minutes.

-Discrimination of form (Beery VMI)

The Beery Visual Motor Integration (VMI) Test investigates the important areas of visual discrimination, figure-ground discrimination, visual completion, and visual memory by a motor response from the patient. There are 23 forms, increasing in difficulty ranging from a simple diagonal line to a complex 3-D form. The subject was given a piece of unlined white paper and pencil, and asked to copy the form "exactly as it appears" onto their paper. They were told no erasing was permitted, and that there was no time limit. (Note: due to the subjectivity of scoring, this test was analyzed by one examiner to keep the inter-examiner reliability high.)
Eye health (direct ophthalmoscopy/external exam)

Ocular health was performed in a completely dark room using the direct ophthalmoscope. It was done as a screening to rule out any gross ocular disease. Only deviations from the norm were recorded. All other outcomes were recorded as "within normal limits".

All tests were non-invasive and often done in the course of a standard visual examination. The visual testing battery took approximately 30 minutes to administer on each child. Scheduling was done in an overlap fashion at 15 minute intervals so that a maximum of three children were out of the classroom at any one time. Testing duration depended on the number of children at each individual school.

The Child Behavior Checklist (CBCL), originally published by Achenbach and Edelbrock (1983) (see Appendix 1), was utilized to establish child behavior profiles. This test consists of 113 questions describing various behaviors which compose distinct behavioral profiles via a standardized test format. The CBCL was completed by the student's classroom teacher (or teaching aide) from typical observations that took place in the course of normal school activity. This test is highly regarded in the field of developmental psychology and has reliable test-retest and internal consistency characteristics.

All data collected were treated in confidence. The only exception to this was the summary report mailed to each parent or guardian explaining the outcome of their child's vision examination.

Data were recorded on standard forms provided by Pacific University and entered into a data base utilizing Filemaker software (see Appendix 2). Results from the two batteries of tests was examined for any associated traits. Data were exported into Excel software for analysis and
The results of the study will be summarized in a final report and made available to appropriate individuals within the corresponding school districts. If it is deemed useful by the school districts, an in-service session will be scheduled at project completion to share the results of the study and discuss pertinent issues.

**Subjects**

Our study sample consisted of seventy “at-risk” juveniles between the age of 11 to 17 years, with a mean age of 15 years. There were twelve participants from an alternative classroom in the public school system in Vernonia, Oregon. Among the twelve, some of the students were self-enrolled into the alternative/vocational program, while others were placed due to lack of academic achievement and/or lack of ability to relate to their peers. Nine participants were from an alternative program in the public school system in Hillsboro, Oregon. These students were placed into the alternative classroom by administrators due to their lack of academic achievement in the regular system. Forty-nine participants were from an all-boys training facility in Beaverton, Oregon. These boys are mainly wards of the court system, and are placed into this training facility in a last strike attempt to rehabilitate them. All the children have serious emotional and behavioral problems. Only those participants that signed a release form were included in the study.

The sample population consisted of 11 percent female and 89 percent male; 2.8 percent of the sample population were black, 92.2 percent were white, and 5 percent were categorized as "other" (e.g. Hispanic decent, Native American).
Results

In our experimental design, the "fail" criteria designated for each of the tests was as follows:

Visual acuity distance and near: 20/40 or worse monocular or o.u.

Refractive status: +1.25 or more of hyperopia; -0.50 or more of myopia; -0.75 or more of astigmatism, monocular or o.u.

Cover test: any tropia

NPC: 6/10 centimeters (3/5) inches or greater

Stereo acuity: 80 seconds of arc or worse

Accommodative facility: 8 sec/cycle or more

Motility (DEM): 25 percentile below age appropriate normative value

Visual Motor Perception (Beery): 1.5 years below age appropriate normative value

Direct ophthalmoscopy: any evidence of ocular disease

Behavioral profiles were assessed by the classroom teacher utilizing the Child Behavior Check List (Achenbach). The teacher assessed each child after a minimum of two months of observation, with a 113-question check list. Failure was any "clinical" score as set by the test norms.

All 70 subjects failed some area of visual function. Scores range from 0% in ocular disease to 70% in visual-motor perception to 71% in refractive status (see Figure 1). All subjects displayed some sort of clinically significant behavior problem ranging from 4% in somatic complaints to 27% in anxious/depressed (see Figure 2).
Comparisons were made as to the visual conditions found vs. the various behavior problems. This is termed co-morbidity. Co-existing conditions with "fail" scores that were 20% congruent or greater for boys were:

- **Refractive status:** withdrawn, anxious/depressed
- **Visual motor perception:** anxious/depressed

Co-existing conditions with "fail" scores that were 20% congruent or greater for girls were:

- **Refractive status:** delinquent behavior
- **Accommodative facility:** thought problems, attention problems, delinquent behavior
- **VMP:** delinquent behavior

The Odds Ratio was computed to determine the relative risk of having a particular behavior profile in the presence of a specific visual dysfunction.

\[
\text{Odds Ratio} = \frac{\text{Cases (exposed)}}{\text{Cases (non-exposed)}} \times \frac{\text{Controls (non-exposed)}}{\text{Controls (exposed)}}
\]

Only those factors whose true risk was at least two times greater were considered.

Relative risk factors of two times or greater for "withdrawn" profile were:

- **Refractive status:** 7.5x
- **Binocular:** 2.28x
- **VMP:** 4.5x

Relative risk factors of two times greater for "anxious/depressed" profile were:

- **Binocular:** 2.13x
- **VMP:** 2.83x
Relative risk factors of two times or greater for "social problems" profile were:

VMP 5.05x

Relative risk factors of two times for "thought problems" profile were:

Binocular 2.31x

Relative risk factors of two times for "attention problems" profile were:

Motility (DEM) 2.5x
VMP 2.6x

Relative risk factors of two times or greater for "delinquent behavior" profile were:

Motility (DEM) 2.14x
VMP 4.6x

Relative risk factors of two times or greater for "aggressive behavior" profile were:

Refractive status 2.6x
Binocular 2.39x

Discussion

The purpose of this research project was to investigate a proactive approach to identifying those in the school system with undiagnosed visual problems and compare these results to the behavior profiles. There has been a great deal of research done on the link between delinquency
and visual dysfunction. David Dzik explored the link between reading ability and juvenile delinquency in the Tennessee court system in 1966\(^9\). Roger Dowis found a significant correlation between learning problems and juvenile delinquency in Boulder, Colorado in 1973\(^8\). A Congressional Report on this topic was presented by the Comptroller General of the United State in 1977\(^4\). More recent studies include Stanley Kaseno's look at visual perception and juvenile delinquency (1985)\(^20\), and Rod Snow's investigation of the visual profiles of at risk youth in Akron, Ohio (1981)\(^23\). Research has also been done on the link between convergence insufficiency and behavior. In 1999, Eric Borsting used the Connor's Rating Scale for Parents to establish a link between behavior and visual dysfunction\(^16\).

However, our research project had a different objective. We set out to find if a well utilized and highly respective behavioral assessment battery (Child Behavioral Checklist) would show some association with children with visual problems. Relative risk factors were evident with refractive disorders, binocular dysfunction, motility (DEM), and visual motor perception. These associations, however, did not yield statistically significant correlations between certain problematic behaviors and visual difficulties. If a larger sample size was utilized, and/or a control group consisting of subjects from the general public school system was included, the results may have shown to be statistically significant. Likewise, a more intensive visual examination may be yield more conclusive correlations. Our screening took cursory glimpses into binocularity, ocular motility and visual motor perception. In addition, none of our subjects were cyclopleged. It is highly possible a lengthy individual exam would yield more visual problems than our screenings. Finally, it is possible that the Child Behavior Check List was not the most sensitive behavior assessment battery. Research should be done with different
standardized behavioral assessment forms to see if another is better at pinpointing the children with behavioral problems.

It is unfortunate that the numbers do not reflect what educators experience on a daily basis--children acting out in class due to a visual problem. Therefore, further research in this area is essential. It would be interesting to see a longitudinal study comparing children with "disruptive behavior" in the early years to those who do not, and compare the degree of academic success in later life.

To identify a problem exists is only half the solution. Once identified, these children need some type of visual intervention to help them be successful in school. One group of subjects in our study will be receiving a course of vision therapy through Pacific University. A follow up study is underway to compare the subjects' behaviors before and after visual intervention.

A standardized, easily utilized approach for identifying children with undiagnosed visual disorders in the classroom must be found to help educators do their jobs successfully--and to protect the interests of the children involved, as well as the greater public.
References


Your answers will be used to compare the pupil with other pupils whose teachers have completed similar forms. The information from this form will also be used for comparison with other information about this pupil. Please answer as well as you can, even if you lack full information. Scores on individual items will be combined to identify general patterns of behavior. Feel free to print additional comments beside each item and in the spaces provided on page 2.

### Pupil's Name

<table>
<thead>
<tr>
<th>Name and Address of School</th>
<th>Name and Address of School</th>
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</table>

### Pupil's Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boy</td>
<td>Male</td>
</tr>
<tr>
<td>Girl</td>
<td>Female</td>
</tr>
</tbody>
</table>

### Pupil's Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Description</th>
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</thead>
</table>

### Pupil's Ethnic Group or Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Description</th>
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</table>

### Today's Date

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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</thead>
</table>

### Pupil's Birthdate (if known)

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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</table>

### Grade in School

<table>
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<tr>
<th>Grade</th>
<th>Description</th>
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### Parents' Usual Type of Work

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<tr>
<th>Type of Work</th>
<th>Description</th>
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### Father's Type of Work

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<th>Type of Work</th>
<th>Description</th>
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</table>

### Mother's Type of Work

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Description</th>
</tr>
</thead>
</table>

### This Form Filled Out By

- Teacher (full name)
- Counselor (full name)
- Other (provide position and full name)

### I. For how many months have you known this pupil? ___________ months

### II. How well do you know him/her?

- 1. Not Well
- 2. Moderately Well
- 3. Very Well

### III. How much time does he/she spend in your class or service per week?

### IV. What kind of class or service is it? (Please be specific, e.g., regular 5th grade, 7th grade math, learning disabled, counseling, etc.)

### V. Has he/she ever been referred for special class placement, services, or tutoring?

- 0. No
- 1. Yes—what kind and when?

### VI. Has he/she repeated any grades?

- 0. No
- 1. Yes—grades and reasons

### VII. Current school performance—list academic subjects and check box that indicates pupil's performance for each subject:

<table>
<thead>
<tr>
<th>Academic Subject</th>
<th>1. Far Below Grade</th>
<th>2. Somewhat Below Grade</th>
<th>3. At Grade Level</th>
<th>4. Somewhat Above Grade</th>
<th>5. Far Above Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<tr>
<td>6.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Below is a list of items that describe pupils. For each item that describes the pupil now or within the past 2 months, please circle the 2 if the item is very true or often true of the pupil. Circle the 1 if the item is somewhat or sometimes true of the pupil. If the item is not true of the pupil, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to this pupil.

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Code 0</th>
<th>Code 1</th>
<th>Code 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acts too young for his/her age</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hums or makes other odd noises in class</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Argues a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fails to finish things he/she starts</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Behaves like opposite sex</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Defiant, talks back to staff</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bragging, boasting</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Can't concentrate, can't pay attention for long</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Can't get his/her mind off certain thoughts; obsessions (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can't sit still, restless, or hyperactive</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Clings to adults or too dependent</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Complains of loneliness</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Confused or seems to be in a fog</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cries a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fidgets</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cruelty, bullying, or meanness to others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Daydreams or gets lost in his/her thoughts</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Deliberately harms self or attempts suicide</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Demands a lot of attention</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Destroys his/her own things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Destroys property belonging to others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Difficulty following directions</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Disobedient at school</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Disturbs other pupils</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Doesn't get along with other pupils</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Doesn't seem to feel guilty after misbehaving</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Easily jealous</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Eats or drinks things that are not food—don't include sweets (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fears certain animals, situations, or places other than school (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fears going to school</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Screening Results

Name of Child ____________________________ Gender _____ Date of Screening ________
DOB ____________________________ Name of Parent or Guardian ________
File Number ____________________________ Name of Teacher __________________

Far Visual Acuity R 20/____ Far Visual Acuity R Hab Rx 201 ________
Far Visual Acuity L 201 ______ Far Visual Acuity L Hab Rx 201 ________
Far Visual Acuity B 201 ______ Far Visual Acuity B Hab Rx 201 ________
Near Visual Acuity R 20/____ Near Visual Acuity R Hab Rx 201 ________
Near Visual Acuity L 20/____ Near Visual Acuity L Hab Rx 201 ________
Near Visual Acuity B 20/____ Near Visual Acuity B Hab Rx 201 ________

Far Visual Acuity R Hab Rx 201 ________ Sharpness of Far Vision
Far Visual Acuity L Hab Rx 201 ________
Far Visual Acuity B Hab Rx 201 ________
Near Visual Acuity R Hab Rx 201 ________ Sharpness of Near Vision
Near Visual Acuity L Hab Rx 201 ________
Near Visual Acuity B Hab Rx 201 ________

Static Ret R Sph ______ Static Ret R Cyl ______ Static Ret R Axis ______
Static Ret L Sph ______ Static Ret L Cyl ______ Static Ret L Axis ______

Cover Test Far ____________________________ Cover Test Near ____________________________
Near Point of Convergence • Break ______ cm
Near Point of Convergence • Recovery ______ cm

Stereopsis • Stereo Fly y/n Stereopsis • Circles ______ arc sec

Accommodative Facility • Binocular at 6 cycles ______ sec Aver per Cycle ______

Raw Sc Percentile Sc Developmental Eye Movements • Horizontal ______ DEM • Horiz Percentile
Developmental Eye Movements • Vertical ______ DEM • Vert Percentile
Developmental Eye Movements • Ratio ______ DEM • Ratio Percentile
Developmental Eye Movements • Error Sc ______ DEM • Err Sc Percentile

Age of Child ______ Days Age of Child in Years ______

Form Perception • Beery Test ______ VMP Age Diff
Beery Score ______

Ocular Health • Anterior R ____________________________
Ocular Health • Posterior R ____________________________
Ocular Health • Anterior L ____________________________
Ocular Health • Posterior L ____________________________

Discrimination of Form
Eye Health

Comments

Please take this form along when you are doing the follow-up examination with a professional vision care provider.