VISION THERAPY STUDIO

2061 Beechmont Avenue #C
Cincinnati, OH 45230

513-232-9555 PHONE
513-232-0400 FAX

VisionTherapyStudio@gmail.com
VisionTherapyStudio.com

two eyes|one team

Quality of Life Survey

Patient: _____ Date: _____

INITIAL EVALUATION RE-EVALUATION FINAL

Check the column that best represents the occurrence of each symptom.

SYMPTOM	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
1. Headaches reading or writing	☐	☐	☐	☐	☐
2. Words slide together when reading	☐	☐	☐	☐	☐
3. Burn, itch, or watery eyes	☐	☐	☐	☐	☐
4. Loses place when reading	☐	☐	☐	☐	☐
5. Head tilt/close one eye when reading	☐	☐	☐	☐	☐
6. Hard to copy from whiteboard	☐	☐	☐	☐	☐
7. Doesn't like reading	☐	☐	☐	☐	☐
8. Doesn't like writing	☐	☐	☐	☐	☐
9. Leaves out small words when reading	☐	☐	☐	☐	☐
10. Hard to write in a straight line	☐	☐	☐	☐	☐
11. Hard to line up numbers when adding	☐	☐	☐	☐	☐
12. Hard to understand what you've read	☐	☐	☐	☐	☐
13. Holds reading material very close	☐	☐	☐	☐	☐
14. Hard to pay attention when reading	☐	☐	☐	☐	☐
15. Hard to finish assignments on time	☐	☐	☐	☐	☐
16. Says "I can't" before trying	☐	☐	☐	☐	☐
17. Bumps into things, knocks things over	☐	☐	☐	☐	☐
18. Runs out of time doing work	☐	☐	☐	☐	☐
19. Loses things	☐	☐	☐	☐	☐
20. Forgetful/poor memory	☐	☐	☐	☐	☐
TOTAL:					

A=Accommodation; B=Binocularity; O=Orientation; OM=Oculomotor; P=Perception

OTHER COMMENTS: _____

_____

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Patient's Name:			
Phone number(s):			
Occupation/Grade:		Patient's Birthdate:	
Employer/ School:			
Home Address:			
City/State/Zip:			
Email Address:			
Current Medications:			
List any medications to which patient is allergic:			
How did you hear about us?			
Parents' names if patient is a child:			

X_____I have read and agree to the Notice of Privacy Practices

Thank you for taking time to fill out this form. We look forward to helping you!

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Patient's Additional History

Patient's Name:		Date:	

Have you noticed any unusual signs/symptoms that concern you?	YES ☐ NO☐		
If yes, please explain:			
Does your child like school?	YES ☐ NO☐	Does your child appear frustrated when doing schoolwork?	YES ☐ NO☐
Has your child had special tutoring, therapy, and/or remedial assistance?	YES ☐ NO☐		
How is your child doing in school?	Well ☐ Below Potential☐ Poorly☐		
If not well, please explain:			
Has the school/another professional expressed concern regarding your child's vision?	YES ☐ NO☐		
If yes, what concern?			
What is your child's attitude toward reading, school, his/her teachers, other peers?			
List any other complaints/concerns your child makes concerning his/her vision:			
Does your child wear glasses, contact lenses, and/or use a special optical device?	YES ☐ NO☐		

Health History and Developmental Milestones:

Full Term Pregnancy?	YES ☐ NO☐	Supplemental Oxygen?	YES ☐ NO☐	Below 5lbs?	YES ☐ NO☐
If complications, please explain:					
Any serious/major falls, injuries, concussions or TBI's?	YES ☐ NO☐				
Explain:					
List any serious or chronic illness:					
Has your child had any surgeries? By whom? For what?					

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Has your child been diagnosed on the autism spectrum?	YES ☐ NO☐
Has your child been through a traumatic family situation?	YES ☐ NO☐
Has anyone in the immediate family had a learning problem?	YES ☐ NO☐

Motor:

Was there ever a reason for concern over your child's general growth or development?			YES ☐ NO☐
If yes, what concern?			
Did your child crawl (stomach off floor)	YES ☐ NO☐	At what age?	
Did your child move around on all fours?	YES ☐ NO☐	At what age?	
At what age did your child walk:		Was your child active?	YES ☐ NO☐

Speech:

First words at what age?		Was speech clear to others?	YES ☐ NO☐
Is speech clear now?	YES ☐ NO☐	Has as occupational/speech/physical therapy evaluation by performed?	YES ☐ NO☐
By Whom?		Results?	

Recreation, Leisure and Devices:

Please list any recreational/sport activities your child participates in:			
Does your child wear protective eyewear for his/her sport?	YES ☐ NO☐		
How much television does your child watch each day?			
How much time does your child use a computer at home?			
How much time does your child spend looking at a smartphone or tablet?			
How much time does your child use a computer at school?			
How much time does your child play video games (TV or handheld)?			
Does your child read for fun?	YES ☐ NO☐	How much daily?	