

Quality of Life Survey

Patient: _____

Date: _____

INITIAL EVALUATION

RE-EVALUATION

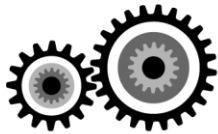
FINAL

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

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

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

OTHER COMMENTS: _____



**VISION
THERAPY
STUDIO**

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Cincinnati, OH 45230

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

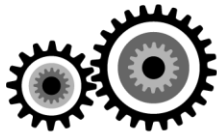
VisionTherapyStudio@gmail.com
VisionTherapyStudio.com

two eyes | one team

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!

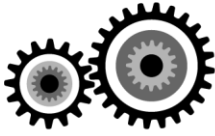


Patient's Additional History

Patient's Name:		Date:	
Have you noticed any unusual signs/symptoms that concern you?			YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes, please explain:			
Does your child like school?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Does your child appear frustrated when doing schoolwork?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Has your child had special tutoring, therapy, and/or remedial assistance?			YES <input type="checkbox"/> NO <input type="checkbox"/>
How is your child doing in school?	Well <input type="checkbox"/>	Below Potential <input type="checkbox"/>	Poorly <input type="checkbox"/>
If not well, please explain:			
Has the school/another professional expressed concern regarding your child's vision?			YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>

Health History and Developmental Milestones:

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



Has your child been diagnosed on the autism spectrum?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has your child been through a traumatic family situation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has anyone in the immediate family had a learning problem?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Motor:

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

Speech:

First words at what age?		Was speech clear to others?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is speech clear now?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Has an occupational/speech/physical therapy evaluation been performed?	YES <input type="checkbox"/>
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 <input type="checkbox"/>	NO <input type="checkbox"/>
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 <input type="checkbox"/>	NO <input type="checkbox"/>
How much daily?		