

Quality of Life Survey

Patient: _____

Date: _____

INITIAL EVALUATION

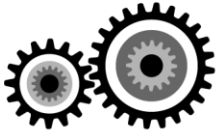
RE-EVALUATION

FINAL

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

SYMPTOM	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS	N/A
1. Headaches/ Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Head tilt/close one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Holds toys very close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Hard to pay attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Hard to make or keep eye contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Says "I can't" before trying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Bumps into things, knocks things over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Runs out of time doing work/takes a long time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Loses things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Forgetful/difficulty following verbal instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Car sickness/ motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Trouble following moving objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Avoids close activities (i.e. coloring)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. One eye turns (in, out, up or down)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Flinches when objects come towards them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Seems to look past you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Red eyes or lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Blinks excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Turns head or body to follow objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Difficulty walking up and down steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL:						

OTHER COMMENTS: _____



VISION
THERAPY
STUDIO

2061 Beechmont Avenue #C
Cincinnati, OH 45230

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

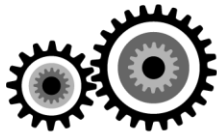
VisionTherapyStudio@gmail.com
VisionTherapyStudio.com

two eyes | one team

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!

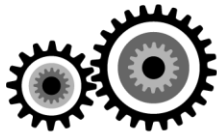


Patient's Additional History

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:			
Has the school/another professional expressed concern regarding your child's vision?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If yes, what concern?			
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?				
At what age did your child sit up on their own?				
Did your child crawl (stomach off floor)	YES <input type="checkbox"/> NO <input type="checkbox"/>	At what age?		
At what age did your child walk:				
Was/Is your child active?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Explain if needed:		

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"/> NO <input type="checkbox"/>
By Whom?		Results?	

Recreation and Leisure:

Please list any recreational/sport activities your child participates in:			
How much television does your child watch each day?			
How much time does your child spend looking at a smartphone or tablet?			
How much time does your child use a computer at home?			
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?	