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	N/A
1. Headaches/ Eyes hurt	☐	☐	☐	☐	☐	☐
2. Head tilt/close one eye	☐	☐	☐	☐	☐	☐
3. Holds toys very close	☐	☐	☐	☐	☐	☐
4. Hard to pay attention	☐	☐	☐	☐	☐	☐
5. Hard to make or keep eye contact	☐	☐	☐	☐	☐	☐
6. Says “I can’t” before trying	☐	☐	☐	☐	☐	☐
7. Bumps into things, knocks things over	☐	☐	☐	☐	☐	☐
8. Runs out of time doing work/takes a long time	☐	☐	☐	☐	☐	☐
9. Loses things	☐	☐	☐	☐	☐	☐
10. Forgetful/difficulty following verbal instructions	☐	☐	☐	☐	☐	☐
11. Car sickness/ motion sickness	☐	☐	☐	☐	☐	☐
12. Trouble following moving objects	☐	☐	☐	☐	☐	☐
13. Avoids close activities (i.e. coloring)	☐	☐	☐	☐	☐	☐
14. One eye turns (in, out, up or down)	☐	☐	☐	☐	☐	☐
15. Flinches when objects come towards them	☐	☐	☐	☐	☐	☐
16. Seems to look past you	☐	☐	☐	☐	☐	☐
17. Red eyes or lids	☐	☐	☐	☐	☐	☐
18. Blinks excessively	☐	☐	☐	☐	☐	☐
19. Turns head or body to follow objects	☐	☐	☐	☐	☐	☐
20. Difficulty walking up and down steps	☐	☐	☐	☐	☐	☐
TOTAL:						

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:			
Has the school/another professional expressed concern regarding your child's vision?		YES ☐	NO☐
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 ☐ 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?					

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☐

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Motor:

Was there ever a reason for concern over your child's general growth or development?			YES ☐ NO☐
If yes, what concern?			
At what age did your child sit up on their own?			
Did your child crawl (stomach off floor)	YES ☐ NO☐	At what age?	
At what age did your child walk:			
Was/Is your child active?	YES ☐ NO☐	Explain if needed:	

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 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 ☐ NO☐	How much daily?	