1605 ROCK PRAIRIE ROAD SUITE 214
COLLEGE STATION, TX 77845
979.541.APEX (2739)
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ADULT'S PROGRESS QUESTIONNAIRE

Please fill out this questionnaire carefully and return it to our office 24 hours prior to your appointment. THANK YOU.

Patient's Name: _____ Date of Birth: _____

Appointment Type: _____ Date: _____ Time: _____

Current Visual Symptoms

Please check your symptoms and write how frequently they occur:

0=Never, 1=Seldom, 2= Occasionally, 3 = Frequently, 4= Always

Refractive Conditions	Yes	No	How frequently (0 through 4)?
Blurred distance vision	☐	☐	
Blurred near vision	☐	☐	
Vision worse at the end of the day	☐	☐	
Headaches	☐	☐	
Eyes hurt or tired after near work	☐	☐	
Avoids reading or other near tasks	☐	☐	
Lag in focus	☐	☐	

Oculomotor Symptoms:	Yes	No	How frequently (0 through 4)?
Moves head when writing or reading	☐	☐	
Skips or repeats lines when reading	☐	☐	
Loss of place when reading	☐	☐	
Uses a finger to keep place	☐	☐	

Eye Teaming (Binocularity) Symptoms	Yes	No	How frequently (0 through 4)?
Closes or covers one eye	☐	☐	
Tilts head	☐	☐	
Reads slowly	☐	☐	
Double vision	☐	☐	

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	Yes	No	How frequently (0 through 4)?
Words move around on the page	☐	☐	
Words run together when reading	☐	☐	
Car or motion sickness	☐	☐	
Poor reading comprehension	☐	☐	
Does not judge distance accurately	☐	☐	

Eye-Hand Coordination Symptoms	Yes	No	How frequently (0 through 4)?
Poor/awkward general motor coordination	☐	☐	
Poor/awkward fine motor coordination	☐	☐	
Clumsy, knocks things over/bumps into things	☐	☐	
Poor/inconsistent in sports	☐	☐	
Writes or prints poorly	☐	☐	
Misaligns digits in a column of numbers	☐	☐	
Writes up/down hill	☐	☐	

Visual Perceptual Symptoms	Yes	No	How frequently (0 through 4)?
Confusion of letters or words	☐	☐	
Reverses letters or words	☐	☐	
Forgetful/poor memory	☐	☐	
Misplaces belongings	☐	☐	
Difficulty attending to details	☐	☐	

Other Visual Symptoms	Yes	No	How frequently (0 through 4)?
Difficulty completing assignments on time	☐	☐	
Gives up easily	☐	☐	
Light sensitive	☐	☐	
Dizziness	☐	☐	

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List any other vision related concerns:

_____

_____

_____

Do you feel your vision interferes with your daily activities in any way? Yes ☐ No ☐ If yes, please explain:

_____

_____

_____

Effectiveness of Vision Therapy

Please describe any new or unresolved concerns since starting therapy:

_____

_____

_____

Please describe how vision therapy has improved your life:

_____

_____

_____

❒ Yes ❒ No May we share your success story with others? (To protect your privacy, only first names would be used.)

❒ Yes ❒ No May we share your contact information with prospective vision therapy students who would like to ask graduates about their experience with vision therapy before deciding to enroll in therapy?