1605 ROCK PRAIRIE ROAD SUITE 214
COLLEGE STATION, TX 77845
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CHILDREN'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: _____

Child Complaints

Does your child complain of, or do you or anyone else continue to notice the following:

Indicate yes or no and how often: 0=Never, 1=Seldom, 2=Occasionally, 3=Frequently, 4=Always

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

Ocular Motility Symptoms	**Yes**	**No**	**Unsure**	**How frequently (0 through 4)?**
Moves head when writing or reading	☐	☐	☐	
Skips or repeats lines when reading	☐	☐	☐	
Loses place while reading	☐	☐	☐	
Uses finger as marker	☐	☐	☐	

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

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	Yes	No	Unsure	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	Unsure	How frequently (0 through 4)?
Poor/awkward large motor coordination	☐	☐	☐	
Poor/awkward fine motor coordination	☐	☐	☐	
Clumsy, knocks things over	☐	☐	☐	
Poor/inconsistent in sports	☐	☐	☐	
Knows material, but does poorly on tests	☐	☐	☐	
Writes poorly or slowly	☐	☐	☐	
Difficulty copying from the chalkboard	☐	☐	☐	
Misaligns digits in a column of numbers	☐	☐	☐	
Writing slants up or downhill	☐	☐	☐	
Cannot stay on or between ruled lines	☐	☐	☐	

Visual Perception Symptoms	Yes	No	Unsure	How frequently (0 through 4)?
Confuses right and left	☐	☐	☐	
Confuses letters or words	☐	☐	☐	
Reverses letters or words	☐	☐	☐	
Forgetful/poor memory	☐	☐	☐	
Trouble following directions	☐	☐	☐	
Difficulty recognizing same word on different page	☐	☐	☐	
Misplaces belongings	☐	☐	☐	
Can't spell known sight words	☐	☐	☐	
Difficulty attending to details	☐	☐	☐	
Vocalizes when reading silently	☐	☐	☐	

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Other Visual Symptoms/Concerns	Yes	No	Unsure	How frequently (0 through 4)?
Says "I can't" before trying	☐	☐	☐	
Difficulty completing tasks on time	☐	☐	☐	
Bothered by light	☐	☐	☐	
Dizziness	☐	☐	☐	

Additional Concerns:

List any other complaints your child continues to make concerning his/her vision:

_____

_____

_____

_____

Do you feel your child's vision continues to hinder his/her daily activities in any way? If yes, how? ☐ Yes ☐ No

_____

_____

_____

_____

Effectiveness of Vision Therapy:

Please describe any new or unresolved concerns since starting therapy:

_____

_____

_____

_____

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Please describe how vision therapy has improved your child's 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?