# The Center for Vision Development & Performance Vision Therapy

***Please return all forms at least 48 hours prior to your appointment by fax, email or regular mail.***

**Home Vision Therapy Progress Report**

1. Have you been able to complete the home exercises on a regular basis? Y N
   If not, why are you having difficulty and how many times a week are they being completed? ______________________________________________

2. Do you understand the home therapy exercises? Y N

3. Are the home therapy exercises explained so they are easy to follow? Y N

4. Is your therapist able to answer your general questions about vision therapy? Y N

5. Are the home therapy exercises too easy, slightly hard or challenging? ______________

6. Which home therapy exercise are you having the most difficulty with? _______________

7. How many hours per day on: computer ____ phone ______ video game _____ TV ____

8. How many hours per day spent: outside ______ inside ______

9. Are you using proper visual hygiene (proper posture, slanted surface, proper lighting, breaks after 20 mins) when reading and writing? Y N

10. What areas in school, sports or on the job **have gotten easier**?
    ______________________________________________________________________

11. What areas in school, sports or on the job **would you like to be easier?**
    ______________________________________________________________________

12. Are there any questions or concerns with in-office vision therapy?
    ______________________________________________________________________

13. What would you like to address in you/your child's upcoming progress evaluation?
    ______________________________________________________________________

Additional comments/concerns: ___________________________________________________

____________________________________________________________________________

Patient Name: _________________________________________ Date: ____________

Parent/Legal Guardian's Name: _______________________ Therapist Name: _____________

# COVD Lifestyle Checklist

Patient Name ______________________________ Completed By ______________________________

Date______________________ Patient Age______________

**After you consider each question, mark the column that applies to the person you are assessing.**

| | NEVER | SELDOM | OCCASIONAL | FREQUENTLY | ALWAYS | SCORE |
|---|---|---|---|---|---|---|
| Blur when looking at near | 0 | 1 | 2 | 3 | 4 | |
| Double vision, doubled or overlapping words on page | 0 | 1 | 2 | 3 | 4 | |
| Headaches while or after doing near vision work | 0 | 1 | 2 | 3 | 4 | |
| Words appear to run together when reading | 0 | 1 | 2 | 3 | 4 | |
| Burning, itching or watery eyes | 0 | 1 | 2 | 3 | 4 | |
| Falls asleep when reading | 0 | 1 | 2 | 3 | 4 | |
| Seeing and visual work is worse at the end of the day | 0 | 1 | 2 | 3 | 4 | |
| Skips or repeats lines while reading | 0 | 1 | 2 | 3 | 4 | |
| Dizziness or nausea when doing near work | 0 | 1 | 2 | 3 | 4 | |
| Head tilts or one eye is closed or covered while reading | 0 | 1 | 2 | 3 | 4 | |
| Difficulty copying from the chalkboard | 0 | 1 | 2 | 3 | 4 | |
| Avoids doing near vision work such as reading | 0 | 1 | 2 | 3 | 4 | |
| Omits (drops out) small words while reading | 0 | 1 | 2 | 3 | 4 | |
| Writes up or down hill | 0 | 1 | 2 | 3 | 4 | |
| Misaligns digits or columns of numbers | 0 | 1 | 2 | 3 | 4 | |
| Reading comprehension low, or declines as day wears on | 0 | 1 | 2 | 3 | 4 | |
| Poor, inconsistent performance in sports | 0 | 1 | 2 | 3 | 4 | |
| Holds books too close, leans too close to computer screen | 0 | 1 | 2 | 3 | 4 | |
| Trouble keeping attention centered on reading | 0 | 1 | 2 | 3 | 4 | |
| Difficulty completing assignments on time | 0 | 1 | 2 | 3 | 4 | |
| First response is “I can’t” before trying | 0 | 1 | 2 | 3 | 4 | |
| Avoids sports and games | 0 | 1 | 2 | 3 | 4 | |
| Poor hand/eye coordination, such as poor handwriting | 0 | 1 | 2 | 3 | 4 | |
| Does not judge distances accurately | 0 | 1 | 2 | 3 | 4 | |
| Clumsy, accident prone, knocks things over | 0 | 1 | 2 | 3 | 4 | |
| Does not use or plan his/her time well | 0 | 1 | 2 | 3 | 4 | |
| Does not count or make change well | 0 | 1 | 2 | 3 | 4 | |
| Loses belongings and things | 0 | 1 | 2 | 3 | 4 | |
| Car or motion sickness | 0 | 1 | 2 | 3 | 4 | |
| Forgetful, poor memory | 0 | 1 | 2 | 3 | 4 | |
| | | | | | TOTAL SCORE | |