The Center for Vision Development & Performance Vision Therapy

Patient Name: _____ DOB:_____ Current Grade: _____

Address:_____ City: _____ Zip: _____

Phone Number: _____ Email:_____

Current School and/or Employer: _____

If patient is a minor: Child resides with: mom & dad mom or dad guardian

Mom's Name: _____Number: _____Email: _____

Dad's Name: _____Number: _____Email: _____

It has been several months or years since your last visit in this office. It is important that you inform our office of any new injuries, symptoms, surgeries or diseases that are significant since your last visit.

Reason for visit: _____

Was this appointment recommended by someone and if so, who? _____

Was vision therapy recommended? Yes No

Did you complete all recommended sessions of vision therapy? Yes No

If yes, what areas of improvement have you seen? _____

What areas are still challenging? _____

If no, how many did you complete? _____ Why did you stop? _____

Are you having new symptoms: Yes No Explain: _____

Do you have any new diagnosis? Yes No Explain: _____

Any new surgeries/hospitalizations? Yes No Explain: _____

If you/your child are currently being seen by any of the following providers, please complete all information

Occupational Therapist: _____ Number: _____
Address: _____ Fax: _____

Psychologist: _____ Number: _____
Address: _____ Fax: _____

Tutor: _____ Number: _____
Address: _____ Fax: _____

Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit? Yes or No

Have you or anyone in your household been tested for COVID-19? Yes or No
Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? Yes or No
Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19? Yes or No
Have you or anyone in your household traveled outside the U.S. in the past 21 days? Yes or No

Patient/Parent Signature: _____ Date: _____

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	