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DELAWARE VISION ACADEMY

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Child Performance Questionnaire

NAME: _____ **DATE: _____**

1.) What specific changes have you seen since your child's last examination or starting treatment?

Study Habits -

Self-esteem -

Cooperation -

Sports/coordination -

School -

2.) How is your child's school performance? Below Average Average Above Average

3.) Are you pleased with the amount of time the therapist has taken to answer your questions after each session? YES NO

4.) Do you feel the therapist thoroughly explains the homework to your child? YES NO

5.) Do you wish to see more emphasis placed on a certain area? YES NO
If so, which area?

6.) Do you have any comments or concerns about the vision therapy program to date?

Weighted Symptom Checklist

- After you consider each symptom, please circle the number that best describes your symptoms.
- **If** there has been a trauma, please note whether or not it was:
  Present before the accident (P), Worsened since the accident (W) or new since the accident (N).

Patient Name_____ **Date**_____

Eye Teaming & Focusing Symptoms (Circle all that apply)	Never	Seldom	Occasional	Frequently	Always	**P/W/N**
Head tilt/ eye closure or cover/ face turn when reading or viewing objects	0	1	2	3	4	
Eyestrain, eye pain, trouble moving eyes, ocular fatigue, rubbing of eyes	0	1	2	3	4	
Eye drift: Left eye Right Eye Inward Outward	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Words appear to run together when reading; words move on the page	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Difficulty copying from the board or taking notes	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Avoidance of or discomfort with near vision work such as reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Car and motion sickness	0	1	2	3	4	
Does not judge distances accurately (difficulty with stairs/catching a ball)	0	1	2	3	4	
Holds books too close or leans to close to computer screen	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Poor hand/eye coordination	0	1	2	3	4	
Unable to maintain eye contact or steady fixation	0	1	2	3	4	
Blurred vision: Near Distance	0	1	2	3	4	
Blurred vision is worse at the end of the day	0	1	2	3	4	
Complains of blurred vision when looking/refocusing from near to far	0	1	2	3	4	
Light sensitivity	0	1	2	3	4	

TOTAL: _____/88

Tracking Symptoms						
Reading comprehension is low or declines as day wears on	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Omits small words while reading	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Substitutes words while reading or copying	0	1	2	3	4	
Head/body movements while reading	0	1	2	3	4	
Fills in the wrong bubbles on computer graded tests	0	1	2	3	4	
Loses place when reading	0	1	2	3	4	

TOTAL: _____/36

Visual Processing Symptoms						
Slow word to word reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
Confuses similar words	0	1	2	3	4	
Can't recognize the same word repeated on a page	0	1	2	3	4	
Trouble with spelling and/or sight vocabulary	0	1	2	3	4	
Trouble learning left from right	0	1	2	3	4	
Reverses letters and numbers	0	1	2	3	4	
Poor spacing when writing; writes up or down hill	0	1	2	3	4	
Awkward posture or pencil grip when writing	0	1	2	3	4	
Seems to know material but does poorly on written tests	0	1	2	3	4	
Poor recall of visually presented material	0	1	2	3	4	

TOTAL: _____/44 (168)

VT Achievement Report

At this point in your therapy program, we want to see what changes you or others have noticed in the following areas.

Please check all areas where improvements have been noticed:

Reading

- ☐ Improved reading
- ☐ Increased interest in reading
- ☐ Improved reading comprehension
- ☐ Reading for longer periods
- ☐ Reading on his/her own
- ☐ Less loss of place while reading
- ☐ Smoother oral reading
- ☐ Reads for fun
- ☐ Words on page don't move around or run together
- ☐ Less sleepiness when reading

Work Changes

- ☐ Better quality work
- ☐ Improved handwriting
- ☐ Fewer problems with work
- ☐ Complete work faster
- ☐ Better spelling
- ☐ Enjoying work more
- ☐ Easier time working
- ☐ Fewer letter reversals

Ocular Symptoms

- ☐ Fewer headaches
- ☐ Better control of eyes
- ☐ Improved distance vision
- ☐ Reduced blur at near
- ☐ Reduced or no double vision
- ☐ Reduced strain/hurting of eyes
- ☐ Improved depth perception
- ☐ Improved vision in a lazy eye
- ☐ Less dependence on glasses
- ☐ Eyes no longer water or tear
- ☐ Better peripheral vision

Emotional & Behavioral Changes

- ☐ Improved self confidence
- ☐ Improved or more positive attitude
- ☐ Improved self-esteem
- ☐ Improved concentration
- ☐ Improved attention span
- ☐ Happier
- ☐ Reduced frustration
- ☐ Improved 'behavior' at home/work
- ☐ Better memory
  (less forgetting of materials, misplacing things, etc)
- ☐ More relaxed
- ☐ Improved family relations
- ☐ Don't 'fidget' as much
- ☐ Less tired or fatigued
- ☐ More outgoing
- ☐ Maintains eye contact

Changes in Localization & Navigation

- ☐ Improvement in sports
- ☐ Less clumsy (not tripping, falling, or bumping into things)
- ☐ Easier driving
- ☐ Better at video games
- ☐ Less dizziness or nausea with near work

Please include any other comments relative to you VT program:

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Thank you for taking the time to completely fill out these forms