

TENNESSEE 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: _____

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COVID Lifestyle Checklist

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