New Vision Eye Care and Rehabilitation Services

Adult's Progress Evaluation Questionnaire

Name____ Date___________

Please take a few minutes to fill this out before your progress evaluation and bring it to your appointment. Your feed back is important to us and to your care.

Please check yes or no to indicate whether or not you have seen improvement in any of these areas that are applicable:

	Yes	No	
Headaches	☐	☐	
Blurriness	☐	☐	
Fatigue	☐	☐	
Double Vision	☐	☐	
Eyes Straight	☐	☐	More often ☐

List any additional symptoms that you feel may be important to this examination:____
____

Have you received any feedback from teachers/coaches/other professionals:____

Have you been willing to try any tasks that were once difficult or threatening?____
______

Has your attention span improved? Yes ☐ No ☐

Has writing improved (sizing,spacing? Yes ☐ No ☐

Has reading improved (fluency,
loss of place, accuracy, etc)? Yes ☐ No ☐

Has comprehension improved? Yes ☐ No ☐

Has your child's attitude toward
toward other students, teachers,
authority figures changed? Yes ☐ No ☐

List changes you have noticed in:

Sports and physical activities_______________________________________

____

Gross motor skills (running, jumping, skipping, balance, etc):

______

______

Fine motor skills (writing, coloring, cutting, etc):

______

______

How are you feeling about the changes seen in your progress at this time?

______

______

______

Thank you.

Date of appointment   Time   ________________