New Vision Eye Care and Rehabilitation Services

Child's Progress Evaluation Questionnaire

Name____ Date___________

Please take a few minutes to fill out before your child's progress evaluation and bring it to your appointment. Your feed back is important to us and to the care of your child. Remember. We need both you and your child at the evauation.

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 gotten any feedback from teachers/coaches/other professionals:____

Has your child been willing to try any tasks that were once difficult or threatening?____
______

At Home: Has behavior improved. Yes ☐ No ☐
Has attention span improved? Yes ☐ No ☐
Following instructions better? Yes ☐ No ☐

At School: Has writing improved (sizing, spacing, etc)? 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 the following:

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 child's progress at this time?

______

______

______

Thank you.

Date of appointment Time ________________