Adult Vision Therapy Intake Form

Full Legal Name: _____

Age: _____

Date of Birth: _____

Email (for report): _____

Phone Number: _____

Occupation: _____

How is speed of reading compared to average? Slower Average Faster

What are the **main** concerns/ issues would you like addressed in your vision therapy/ binocular vision assessment?

_____

_____

_____

_____

_____

_____

History of head injury? Y N

If yes, when? _____

Have you had a head scan? Y N

Please list any current medications:

_____

_____

Would you like a letter requesting for insurance coverage? Y N N/A

How often does each symptom occur?

Please answer the following to the best of your abilities.

	Never	Occasionally	Often	Always
Eyes feel tired or hurt				
Headaches during or after reading or near work				
Fatigue easily with near work				
Dizziness, nausea with near work				
Carsickness/motion sickness				
Sensitive to light				
Flashes of light				
Dry eyes or excessive tearing of eyes				

Blurry vision at near				
Words shake or jump when reading				
Discomfort when reading, computer or near work and/or fatigue easily				
Dislike/avoid close work				
Head close to paper when reading or writing				
Vision blurs for a bit when changing from near to far and vice versa				

	Never	Occasionally	Often	Always
See double				
Close one eye when doing visual activity				
Eye turn when looking straight				
Letters, words, or lines moving on page				
Has head close to paper				
Poor depth perception and/or inability to estimate distances accurately				
Difficulty stepping up or down stairs				
Write up or downhill when supposed to be straight				
Difficulty seeing 3-D in 3-D movies				
Trouble judging distance when parking/pulling into traffic (if applicable)				
Difficulty with night driving (if applicable)				

Lose place when reading and/or skip, reread words, letters, lines, phrases				
Mistake words with similar beginnings or endings				
Use finger when reading				
Eye/hand coordination is difficult				
Read slowly				

Trip or stumble when walking				
Difficulty with small hand tools				
Write slow but neatly				
Tendency to knock things over table/desk				
Easily distracted				
Uncomfortable in crowded areas of movement				

Forget that a same word was seen in sentence or page before				
Difficulty with memory				
Difficulty sounding out of letters/words				
Say words aloud or moves lips while reading “silently”				
Poor ability to remember or comprehend what is read				
Confuse left and right				
Confuse similar letters (ie p,d,b,q)				
Confuse similar numbers (ie 6,9)				
Difficulty with spelling				