HELLERSTEIN & BRENNER
VISION CENTER, P.C.

TRICIA BRENNER, O.D. • SHELBY RILEY, O.D. • SARA GRELL, O.D. • KYARA FARINELLA, O.D. • AMY OVERLAND, O.D.

PROGRESS EVALUATION QUESTIONNAIRE

Name_____
Date_____

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

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_____
Red eyes	_____	_____	

List any additional symptoms that you feel may be important to this exam.

_____

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 other students, teachers, authority figures changed?	Yes_____	No_____

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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 child's progress at this time?

_____

_____

_____

How is your (the patient) over all general health? Excellent___ Good____ Fair___ Poor_____
Medications/Vitamins/Supplements: _____
Allergies: _____
Does the patient (Circle those that apply) Smoke Use Recreational Drugs
Health Issues: Diabetes___ High Blood Pressure___ Hormone Replacement ___Thyroid ___
Neurologic disorders__ Any other eye Disease ___

Thank you.

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