VT ACHIEVEMENT REPORT

Patient's Name ______________________ Date of this report ______________

At this point in your therapy program we want to see what changes you, your parents or others have noticed in the following areas.

Please check all areas where you have noticed improvement.

READING

- ☐ 1. Improved reading
- ☐ 2. Increased interest in reading
- ☐ 3. Improved reading comprehension
- ☐ 4. Reading for longer periods
- ☐ 5. Reading on his/her own
- ☐ 6. Less loss of place while reading
- ☐ 7. Smoother oral reading
- ☐ 8. Reads for fun
- ☐ 9. Words on page don't move around or run together
- ☐ 10. Less sleepiness when reading

ACADEMIC CHANGES

- ☐ 1. Better grades in school
- ☐ 2. Better quality schoolwork
- ☐ 3. Improved handwriting
- ☐ 4. Fewer problems with homework
- ☐ 5. Completes school work
- ☐ 6. Better spelling
- ☐ 7. Better math
- ☐ 8. Enjoying school more
- ☐ 9. Easier time studying
- ☐ 10. Fewer letter reversals

OCULAR SYMPTOMS

- ☐ 1. Fewer headaches
- ☐ 2. Better control of eyes
- ☐ 3. Improved distance vision
- ☐ 4. Reduced blur at near
- ☐ 5. Reduced or no double vision
- ☐ 6. Reduced strain/hurting of eyes
- ☐ 7. Improved depth perception
- ☐ 8. Improved vision in a lazy eye
- ☐ 9. Less dependence on glasses
- ☐ 10. Eyes no longer water or tear
- ☐ 11. Better peripheral vision

EMOTIONAL & BEHAVIORAL CHANGES

- ☐ 1. Improved self confidence
- ☐ 2. Improved or more positive attitude
- ☐ 3. Improved self-esteem
- ☐ 4. Improved concentration
- ☐ 5. Improved attention span
- ☐ 6. Happier
- ☐ 7. Reduced frustration
- ☐ 8. Improved "behavior" at home/school
- ☐ 9. Better memory (less forgetting of materials, misplacing things, etc.)
- ☐ 10. More relaxed
- ☐ 11. Improved family relations
- ☐ 12. Doesn't "fidget" as much
- ☐ 13. Less tired or fatigued
- ☐ 14. More outgoing
- ☐ 15. Maintains eye contact

CHANGES IN LOCALIZATION & NAVIGATION

- ☐ 1. Improvement in sports
- ☐ 2. Less clumsy (not tripping, falling, or bumping into things
- ☐ 3. Easier driving
- ☐ 4. Better at video games
- ☐ 5. Less dizziness or nausea with near work

Please include any other comments relative to your vision therapy program:

Thank you for taking the time to completely fill out the form.

COVD – College of Optometrists in Vision Development
Symptom Checklist

Patient Name:______________________________ **Date of Birth:**____________________

Symptoms and Observations How often does each behavior occur?	Never (0)	Seldom (1)	Occasionally (2)	Frequently (3)	Always (4)
Blurred close vision					
Double vision					
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Falls asleep while reading					
Sees worse at the end of the day					
Skips/repeats lines when reading					
Dizzy/nauseated by near work					
Head tilt/one eye closed to read					
Difficulty copying from the chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes uphill/downhill					
Misaligns digits/columns of numbers					
Poor reading comprehension					
Poor/inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing work on time					
Says "I can't" before trying					
Avoids sports/games					
Poor hand/eye coordination					
Poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Poor time use/management					
Does not make change well					
Loses things/belongings					
Car or motion sickness					
Forgetfulness/poor memory					

Total: ______________