BEHAVIORAL SURVEY

Please complete this form for the patient, whether that be yourself or your child.

PATIENT'S NAME:_____ **DATE OF BIRTH:**_____
If this form is completed by a parent/guardian, what is your relationship to the child?_____

PRESENT SITUATION: In what ways do you seem to have difficulty? (How does your child complain about his or her vision?)

_____

_____

Has anyone noticed an eye turn in or wander out? YES / NO Which eye? _____ When? _____

Do you experience any of the following. If yes, when?

Headaches	YES / NO When _____	Eyes Hurt or Tired	YES / NO When _____
Blurred Vision Far	YES / NO When _____	Double Vision	YES / NO When _____
Blurred at Near	YES / NO When _____	Light Sensitivity	YES / NO When _____

Have you ever noticed the following?

Holding reading close	YES / NO When _____
Holding reading farther away	YES / NO When _____
Distorted posture when reading	YES / NO When _____
Inability to see distance objects	YES / NO When _____
Closing one eye	YES / NO When _____
Covering one eye	YES / NO When _____
Bumping into objects	YES / NO When _____
Poor general coordination	YES / NO When _____
Eyes frequently reddened	YES / NO When _____
Frequent styes	YES / NO When _____
Excessive eye rubbing	YES / NO When _____
Skips words or rereads	YES / NO When _____
Reverses words/letters	YES / NO When _____
Moves lips while reading quietly	YES / NO When _____
Get lost in book/unaware of surroundings	YES / NO When _____
Moves head while reading	YES / NO When _____
Uses finger to follow words	YES / NO When _____
Tilts head while reading	YES / NO When _____
Bothered by light	YES / NO When _____

Does the patient have a speech or language deficit? YES / NO
If Yes, has any attempt been made to correct it? YES / NO By Whom? _____
Was therapy helpful? YES / NO

Have you ever had any eye surgeries or injuries? YES / NO Please Explain _____
Have you ever had vision therapy? YES / NO When? _____ By Whom? _____
Was it helpful? YES / NO _____

Does your job/school include using a computer/tablet? _____hours/day
How do you spend your free time? _____
How many hours a day do you: _____use a digital device _____read _____watch TV
Are you involved in sports? YES / NO Which one(s) _____
What kind of exercise do you do? _____