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Adolescent Mid-Therapy Questionnaire

Name of Patient	Exam Date	Chart #
Date of Birth (MM / DD / YYYY)	Grade level	
Name of person completing this form		

Please let us know if there have been any changes with patient's demographic information since starting the therapy program:

☐ Please check if no changes

1) List initial goals when entering the therapy program.

2) List any areas where you feel progress has been made towards achieving initial goals.

3) Does your child report any of the following currently? Please check (☐) all areas of concern.

☐ 1. Blurred vision (far)	☐ 8. Loses place often when reading	☐ 15. Covers or closes one eye
☐ 2. Blurred vision (near)	☐ 9. Repeatedly omits "small" words	☐ 16. Tilts/turns head to one side
☐ 3. Headaches	☐ 10. Skips or rereads words/lines	☐ 17. Moves head when reading
☐ 4. Avoids close work	☐ 11. Uses finger/marker to keep place	☐ 18. Mistakes words with similar beginnings or endings
☐ 5. Squints to see blackboard	☐ 12. Poor reading comprehension	☐ 19. Complains of letters/lines "floating", "running together" or "jumping"
☐ 6. Fatigues easily during visual tasks	☐ 13. Complains of seeing double	
☐ 7. Frequent eye rubbing or blinking	☐ 14. One eye turns (in, out, up or down)	

4) Have you seen any improvements in the following areas listed below?

Please check (☐) all that apply.

☐ 1. Confuses left/right directions	☐ 15. Cannot remember exact order of items in left to right sequence
☐ 2. Confuses b-d-p-q	☐ 16. Difficulty retaining spelling words from week to week
☐ 3. Reverses letters/words when writing/copying	☐ 17. Confuses similar beginnings and endings of words
☐ 4. Difficulty sounding out unfamiliar words	☐ 18. Unable to “picture” descriptions or instructions
☐ 5. Fails to recognize same word in next sentence	☐ 19. Demonstrates poor reasoning and learning strategies
☐ 6. Confuses likenesses and minor differences	☐ 20. Difficulty relating letters to their relevant sounds
☐ 7. Mistake words with similar beginnings	☐ 21. Poor reading speed
☐ 8. Difficulty recognizing letters or simple forms	☐ 22. Sloppy drawing or writing skills
☐ 9. Inability to line up math problems	☐ 23. Difficulty manipulating or handling small objects
☐ 10. Difficulty copying from black board	☐ 24. Cannot complete written tasks in allotted time
☐ 11. Difficulty distinguishing main idea from insignificant details	☐ 25. Difficulty catching/hitting ball/dislikes sports
☐ 12. Awkward gait	☐ 26. Short attention span
☐ 13. Demonstrates poor memory	☐ 27. Distractible
☐ 14. Trouble writing/remembering letters/numbers	

5) Please use the following scale to rate each symptom:

	None	Mild	Moderate		Severe		None	Mild	Moderate		Severe
Circle one number	**0**	**1**	**2**	**3**	**4**	*Circle one number*	**0**	**1**	**2**	**3**	**4**
Headache	0	1	2	3	4	Difficulty concentrating	0	1	2	3	4
Nausea	0	1	2	3	4	Feeling mentally foggy	0	1	2	3	4
Vomiting	0	1	2	3	4	Difficulty remembering	0	1	2	3	4
Sensitivity to light	0	1	2	3	4	Attention difficulty	0	1	2	3	4
Sensitivity to noise	0	1	2	3	4	Feeling slowed down	0	1	2	3	4
Visual Problems	0	1	2	3	4	Sadness/hopelessness	0	1	2	3	4
Dizziness	0	1	2	3	4	Nervous/anxious	0	1	2	3	4
Lightheadedness	0	1	2	3	4	Irritability	0	1	2	3	4
Balance problems	0	1	2	3	4	More emotional	0	1	2	3	4
Numbness/tingling	0	1	2	3	4	Motion sensitivity	0	1	2	3	4
Fatigue	0	1	2	3	4	Ruminating thoughts	0	1	2	3	4
Trouble falling asleep	0	1	2	3	4	Difficulty in Math	0	1	2	3	4
Sleeping more than usual	0	1	2	3	4	Difficulty reading	0	1	2	3	4
Sleeping less than usual	0	1	2	3	4	Symptoms worse at end of day	0	1	2	3	4
Drowsiness	0	1	2	3	4						

6) Please list any changes in general health since the last visit.

7) Please list all current medications and dosages.

☐ Please check if no changes

8) Have there been any illnesses/injuries, operations or hospitalizations since your last visit?

☐ Yes ☐ No (If yes, please list details)

9) List any additional concerns you need to share with Dr. Mackowsky today.

Signature (please circle: patient/parent/spouse/caretaker) Date

Dr. Mackowsky's Signature Date