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Adult Exit Therapy Questionnaire

Name of Patient	Exam Date	Chart #
Date of Birth (MM / DD / YYYY)	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 all initial goals that have been achieved.

2) List any areas of continuing concern.

3) Symptom ratings

For each statement below, give a rating (scale of 0-4, 4 being severe) that best reflects how the symptom affects you currently.

Circle one number for each statement (4 = severe)	0	1	2	3	4
Cognition					
I experience brain fog	0	1	2	3	4
My thinking feels slowed	0	1	2	3	4
I have difficulty remembering	0	1	2	3	4
I have difficulty focusing/maintaining attention	0	1	2	3	4
Mental activity causes fatigue/cognitive overload	0	1	2	3	4
Ocular (Vision)					
I experience blurred or double vision	0	1	2	3	4
I experience eye strain	0	1	2	3	4
I have difficulty reading/visually tracking objects	0	1	2	3	4
Visual activities contribute to headaches	0	1	2	3	4
I have difficulty judging depth or distance	0	1	2	3	4
Affective (Emotional Regulation)					
I experience anxiety or panic	0	1	2	3	4

Circle one number for each statement (4 = severe)	0	1	2	3	4
I experience depression or persistent low mood	0	1	2	3	4
I experience mood swings or irritability	0	1	2	3	4
I withdraw from social activities or other people	0	1	2	3	4
I have difficulty with motivation	0	1	2	3	4
Cervical (Neck and Posture)					
I experience neck pain	0	1	2	3	4
I experience neck stiffness	0	1	2	3	4
My neck feels unstable or difficult to control	0	1	2	3	4
I experience headaches or dizziness associated with neck symptoms	0	1	2	3	4
I experience posture-related discomfort or difficulty maintaining posture	0	1	2	3	4
Headache					
I experience migraine-type headaches	0	1	2	3	4
I experience tension-type headaches	0	1	2	3	4
I experience sensitivity to light	0	1	2	3	4
Light or noise triggers or worsens my headaches	0	1	2	3	4
Stress/physical exertion worsens my headaches	0	1	2	3	4
Cardiovascular (Autonomic Regulation & Circulation)					
I experience dizziness or lightheadedness	0	1	2	3	4
I experience fatigue that limits my daily activities	0	1	2	3	4
I experience brain fog along with dizziness/fatigue	0	1	2	3	4
I have difficulty tolerating physical exertion	0	1	2	3	4
I have difficulty judging depth or distance	0	1	2	3	4
Vestibular (Balance & Spatial Awareness)					
I experience motion sensitivity	0	1	2	3	4
I experience dizziness or nausea	0	1	2	3	4
I feel unsteady/have difficulty maintaining balance	0	1	2	3	4
My symptoms worsen in busy or visually complex environments	0	1	2	3	4
I experience blurry vision or discomfort during car travel or movement	0	1	2	3	4
Auditory (Sound Processing & Brain Integration)					
I experience sensitivity to sound	0	1	2	3	4
I experience ringing or other noises in my ears	0	1	2	3	4
I have difficulty processing or understanding spoken information	0	1	2	3	4
I feel overwhelmed in noisy environments	0	1	2	3	4
I have difficulty judging where sounds come from	0	1	2	3	4
Autonomics (Nervous System Regulation)					
I have difficulty regulating my body temperature	0	1	2	3	4
I experience gastrointestinal or digestive symptoms	0	1	2	3	4
I experience disturbed or unrefreshing sleep	0	1	2	3	4
I experience persistent or unexplained fatigue	0	1	2	3	4
I notice unusual or uncomfortable changes in my heart rate	0	1	2	3	4

**Adapted from the COACH CVA2 Clinical Guideline Overview*

Activities or situations that worsen symptoms:

4) Please list any changes in your general health since your last visit.

5) Please list all current medications and dosages.

☐ Please check if no changes

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

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

7) Would you be willing to serve as a reference for prospective therapy patients?

☐ Yes ☐ No

8) Please consider sharing your experience with our clinic by scanning the QR code below to provide feedback about your therapy program. Your input helps us continuously improve our patient experience.

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

Dr. Mackowsky's Signature Date