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KC Vision Performance
Vision Therapy • Neuro-Optometry • Low Vision Rehab
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Vision Therapy Intake Form

Patient Name:____ **Today's Date:**_____________

VISION HISTORY

Please describe the vision or performance complaints you are here to resolve.

At what age did the problem begin?

Describe the current status of the concern.

Does anyone in the family have a similar problem? If yes, which family member? Yes No

Does the patient currently wear glasses or contacts (circle one or both)? What for (reading, sports, etc.)?

Date of last eye exam?

What was the eye doctor and clinic's name?

Do you want us to send reports to the doctor(s) listed above? If so, please circle them or list additional doctors to send reports.

PREVIOUS THERAPY

Has the patient done Vision Therapy in the past? Yes No

If yes, please describe the treatment program recommended and the results.

Was the treatment program followed? Yes No

What was the vision therapy Clinic's name?

Please list any other therapy programs that have been recommended. (OT, PT, Speech, etc.)

Describe the outcomes of other therapy programs completed.

Is there any other information you'd like to share?