VISION REHABILITATION CENTER

Please complete this form prior to your sports vision evaluation.

ATHLETE INFORMATION

Name: _____ **Date of Birth:** _____

Age: _____ **Dominant Hand/Foot:**_____

Sport(s): _____ **Position(s):**_____

Competition Level:

☐ Recreational ☐ Travel / Club ☐ Varsity / JV

☐ College ☐ Elite / Professional ☐ Military / First Responder

GOALS & PERFORMANCE CONCERNS

Primary reason(s) for visit (check all that apply):

☐ Improve overall performance ☐ Improve reaction time ☐ Difficulty tracking ball / object

☐ Depth perception / timing issues ☐ Recovering from concussion ☐ Coach or parent referral

☐ Reduce errors under pressure ☐ Visual fatigue during play ☐ Pre-season baseline assessment

Additional performance goals:

VISION & HEALTH HISTORY

Current vision correction:

☐ None ☐ Glasses ☐ Contact lenses

☐ Sports goggles / protective eyewear ☐ LASIK / Refractive surgery

Last eye exam: _____ **Treating eye doctor (if any):** _____

Current visual symptoms (check all that apply):

☐ Blurry distance vision ☐ Blurry near / intermediate vision ☐ Double vision

☐ Eyestrain / headaches ☐ Slow focus shift (near to far) ☐ Light sensitivity / glare

☐ Night vision difficulty ☐ Motion sickness / dizziness ☐ Halos or starbursts around lights

☐ Dry or irritated eyes ☐ None

Additional information:

_____

_____

SPECIFIC CONSIDERATIONS

Primary playing environment:

☐ Indoor ☐ Outdoor - daytime ☐ Outdoor - night / under lights ☐ Mixed / variable conditions

CONCUSSION / HEAD INJURY HISTORY

History of concussion or head injury:

☐ No ☐ Yes - 1 concussion ☐ Yes - 2 concussions ☐ Yes - 3 or more

Date(s) of injury: _____ **Cleared to play (date):** _____

Current or ongoing post-concussion symptoms:

☐ Headaches ☐ Dizziness / balance issues ☐ Blurred vision

☐ Light sensitivity ☐ Slow reaction time ☐ Trouble concentrating

ATTENTION & VISUAL PROCESSING

☐ Difficulty concentrating during play	☐ Easily lose track of ball / object	☐ Overwhelmed in busy environments
☐ History of ADHD / learning differences	☐ Difficulty reading plays quickly	☐ Trouble anticipating opponent's moves
☐ Distracted by crowd / sidelines	☐ Difficulty processing under pressure	☐ None of the above

TRAINING & LIFESTYLE

Practice hrs / week:	**Strength & Conditioning days / week:**	**Avg. sleep hrs / night:**

Prior vision therapy or sports vision training:

☐ None	☐ Currently in VT program	☐ Completed VT (when?)	☐ Sports vision training (apps / tools)

If yes, describe: _____ **Provider:** _____

Average daily screen time (phone / tablet / gaming / computer):

☐ Less than 2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ More than 6 hrs

Please rate the importance of vision in your chosen sport (1= not important; 9= extremely important).

1 2 3 4 5 6 7 8 9