# Active Therapy Progress Check Form

**NAME**: _____ **DATE**: _____

**Instructions**: Circle the severity of symptoms **0 = no symptoms / 4 = severe**

Symptoms:

| | | | |
|---|---|---|---|
| 0 1 2 3 4 | **Headaches** | 0 1 2 3 4 | **Attention Problems** |
| 0 1 2 3 4 | **Problems Focusing** | 0 1 2 3 4 | **Neck Pain** |
| 0 1 2 3 4 | **Double Vision** | 0 1 2 3 4 | **Disorientation** |
| 0 1 2 3 4 | **Eye Pain/Strain** | 0 1 2 3 4 | **Dizziness** |
| 0 1 2 3 4 | **Eye Fatigue** | 0 1 2 3 4 | **Memory Problems** |
| 0 1 2 3 4 | **Words Move on Page** | 0 1 2 3 4 | **Anxiety/Worry** |
| 0 1 2 3 4 | **Motion/Car Sickness** | 0 1 2 3 4 | **Depression/Despair** |
| 0 1 2 3 4 | **Movement Sensitivity** | 0 1 2 3 4 | **Anger/Irritability** |
| 0 1 2 3 4 | **Light Sensitivity** | 0 1 2 3 4 | **Overwhelm/Emotional** |
| 0 1 2 3 4 | **Nausea** | 0 1 2 3 4 | **Excitement/Joy** |
| 0 1 2 3 4 | **Clumsiness** | | |

**What has improved since the last progress check (reading, writing, attention, coordination, anxiety)?**

**What concerns remain that were not in the symptom checklist above?**

**PC**

# PROGRESS CHECK (OFFICE USE)

**NAME:** _____
**DATE:** _____ **PC #:** _____
**EST. SESSIONS:** _____ **COMPLETED:** _____
**PROBLEMS WITH HW: YES / NO**
**NOTES:**

**CURRENT RX:** _____ **OD** _____
_____ **OS** _____
_____ **ADD** **OU** _____

**COVER TEST:**

| NEAR | | | DIST | | |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

**OCULAR MOTILITIES:**
**FROM / SMOOTH / RESTRICTION:** _____
**WORSE WITH R / L BRAIN STIMULATION**
**JUMPS: LG / MED / SM / MIDLINE**
**SACCADES: FULL / UNDER / OVERSHOT**
**CNP:** _____ / _____

**STEREO (RANDOT BUTTERFLY):**
**GLOBAL: YES / NO +/- 6cm-1m ANIM/CIRC:** _____

| WORTH 4 DOT DV | NV | +/-2.00 |
|---|---|---|
| _____ | _____ | _____ / _____ |

**VF: FTHM /** _____ **PA:** _____

**7A OD** _____ **OD** _____
**OS** _____ **OS** _____
**OU** _____

**DIST PHORIA 8**
**8** _____

**DISTANCE EQUILIBRIUM**
**9/10** _____ ( ) /_____ /_____ **S I L O**
**11** _____ ( ) /_____ / _____ **S I L O**

**FUSED CROSS CYLINDER**
**14B +**_____ **A G**

**NEAR PHORIA with 14B**
**15B** _____

**NEAR EQUILIBRIUM**
**16** _____ ( ) /_____ /_____ **S I L O**
**17** _____ ( ) /_____ /_____ **S I L O**

**PRA/NRA**
**21 +** _____ **A G**
**20 -** _____ **A G**

**REFLEXES:**

| | INT | MILD | MOD | SEV |
|---|---|---|---|---|
| **MORO:** | ____ | ____ | ____ | ____ |
| **TLR:** | ____ | ____ | ____ | ____ |
| **ATNR:** | ____ | ____ | ____ | ____ |
| **STNR:** | ____ | ____ | ____ | ____ |

**BLIND FINGER TOUCH:**

| RH | | LH | |
|---|---|---|---|
| + | + | + | + |

**Z-BELL/BLIND SNAP:**

| | | | |
|---|---|---|---|
| + | + | + | + |

| HI | | LOW | |
|---|---|---|---|
| + | + | + | + |

**ASSESSMENT:**

| | Score 1 - 10 | | |
|---|---|---|---|
| **VIS ACUITY** | _____ | **EYE-HAND** | _____ |
| **DIST POSTURE** | _____ | **EYE-BODY** | _____ |
| **NEAR POSTURE** | _____ | **BODY-BODY** | _____ |
| **Eye MVMT** | _____ | **AUTOMAT** | _____ |
| **PERIPH** | _____ | **LAT/Direct** | _____ |
| **EYE TEAMING** | _____ | **VIS-PERCEPT** | _____ |
| **ACCOM** | _____ | **OC HEALTH** | _____ |
| **EYE-EAR** | _____ | | |

**PLAN:**

**CHANGE RX:** _____
_____
_____ **ADD FTW / NEAR / DIST**
**CONTINUE VT / DISCONTINUE VT / MODIFY VT**

**RTC:**

**NOTES:**

**DR. SIGNATURE:** _____

**PC**