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POST VISION THERAPY QUESTIONNAIRE

Name of patient ______________________

Name of person completing this questionnaire and relationship to patient ______________________

1. Why did you choose Restore Eye Care and Gym for your vision needs?

2. What were your symptoms or problems that you hoped vision therapy would help?

3. Did vision therapy address those concerns?

4. How has your day to day life improved since completing vision therapy?

5. Do you have any other concerns or observations you would like to share?

You have my permission to publicly publish this information and my photo on Restore Eye Care and Gym websites, Facebook, or related social media and advertisements, as well as to share this information with current and future patients of Restore Eye Care and Gym. I understand that signing this is not required to complete or submit this questionnaire. If I do not sign this, my information will remain private.

Signature ______________________

Date ______________________