



Neuro-Developmental Reflex Program Review

The **VISION** Development Team

Patient's Name: _____ Age: _____ Grade: _____ Date: _____

1. How often is your child performing their exercises?

2. Describe any difficulties in carrying out the exercises:

Check off any areas that your child is showing signs of improvement

- | | | |
|---|---|--|
| <input type="checkbox"/> Sitting still | <input type="checkbox"/> Understanding directions | <input type="checkbox"/> Sports performance |
| <input type="checkbox"/> Waiting quietly | <input type="checkbox"/> Balance | <input type="checkbox"/> Telling time |
| <input type="checkbox"/> Reading without losing place | <input type="checkbox"/> Eye control/Convergence | <input type="checkbox"/> Knowing right from left |
| <input type="checkbox"/> Comprehension | <input type="checkbox"/> Eye teaming | <input type="checkbox"/> Coordination |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Writing | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Math | <input type="checkbox"/> Interest in school | <input type="checkbox"/> Muscle tone |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Decreasing reversals | <input type="checkbox"/> Alertness/ Energy level |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Confidence | <input type="checkbox"/> Social skills |
| <input type="checkbox"/> Listening | | <input type="checkbox"/> Motivation |
| | | <input type="checkbox"/> Decreased irritability |

Other areas of improvement:

Areas of concern:

List topics you would like to discuss during the review: