



International Sports Vision Association™

Maximizing Athletic Performance Through
Vision Training and Enhancement

SPORTS VISION QUESTIONNAIRE

In sports, vision has the potential to affect an athlete's performance. So that we may begin to better understand the visual factors that may contribute to helping you achieve peak performance, please fill out this brief questionnaire and bring it with you on the day of your appointment.

1. Athlete Information

Last Name First Name

Date of Birth

Address

City State Zip

Telephone

Email

2. Tell Us About Yourself

Parent please fill out for minor.

Primary Sport Position(s)

Level you now play (check one):

- Recreational/Intramural School Team or Sports Club
 Amateur Professional

Coach/Athletic Trainer

Additional Sports & Activities

Please complete the following, if applicable:

- What hand do you throw with? Right Left Switch
Which way do you bat/swing? Right Left Switch
Which foot do you kick with? Right Left Switch

Which eye would you consider to be more dominant?

- Right Left Not sure

Have you ever had a concussion or head injury?

- Yes No

If Yes, when was the most recent concussion?

If Yes, how many concussions have you had in your life?

3. Visual History

Date of most recent eye exam

Name of Provider of last eye exam

Do you wear vision correction while playing sports?

- Yes No

If yes, check all that apply: Glasses Contacts Both

Do you take any nutritional supplements? Yes No

If yes, please list

Would you like us to send a progress report to your eye care practitioner and/or athletic trainer/coach upon completion of a performance vision training program? Yes No

If yes, please provide name and contact information
(email or mailing address)

4. Visual Performance

Please note how often you experience each item below:

| EYEWEAR USED FOR SPORTS | Never | Seldom | Occasionally | Frequently | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| I wear my everyday wear glasses/sunglasses when playing sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wear contact lenses when playing sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wear sports-specific protective eyewear when playing sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| BEFORE I GO OUT ON THE FIELD/COURT | Never | Seldom | Occasionally | Frequently | Always |
| I do visual exercises to enhance my vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| WHEN PLAYING SPORTS, I... | Never | Seldom | Occasionally | Frequently | Always |
| Have difficulty seeing/following moving targets (i.e., Ball, puck, opponent) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty judging speed, distance, spin, or location of ball/puck or teammates/opponents | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Experience loss of concentration/focus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have trouble with balance and/or timing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have trouble with depth perception (over- or under-estimate distances) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Find indoor lighting uncomfortable (too much glare) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Am sensitive to bright sun or light when playing outdoors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty seeing at dusk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty adapting to changes in lighting (i.e., moving from shade into sun) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty distinguishing different colors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty distinguishing between teammates/opponents | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Find that my side (peripheral) vision is distorted | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty positioning myself in relation to other people or objects (i.e., lining up correctly in football) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Am unable to screen out visual or audible distractions and stay focused | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Notice reduced performance as stress builds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty remembering details from previous performance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please give a brief description of your sport performance, highlighting your strengths and weaknesses as an athlete:

Is there any aspect of your visual function that you feel limits or restricts your performance? (If yes, please explain):

What areas would you like to improve?:

- | | |
|--|---|
| <input type="checkbox"/> Tracking | <input type="checkbox"/> Judging Distance |
| <input type="checkbox"/> Reaction Time | <input type="checkbox"/> Judging Speed |
| <input type="checkbox"/> Peripheral Awareness | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Eye-Hand Coordination | <input type="checkbox"/> Attentional Focus |
| <input type="checkbox"/> Visualization | <input type="checkbox"/> Consistency in Performance |
| <input type="checkbox"/> Depth Perception | <input type="checkbox"/> Decreasing Distractibility |

If not listed above, please list any specific areas you would like to improve in your game:

Athlete Signature

Date Signed

Name of Parent/Guardian (if signing for minor)

Parent/Guardian Signature