Dynamic
VISION THERAPY
PLLC

# Symptom Checklist

Name: _____ Date: _____

Please complete this questionnaire. After each symptom listed, circle the number that best describes how often you experience that particular problem.

**0=never, 1=seldom, 2= occasionally, 3=frequently, 4=always**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Blurred vision at near | 0 | 1 | 2 | 3 | 4 |
| 2. | Double vision | 0 | 1 | 2 | 3 | 4 |
| 3. | Headaches associated with near work | 0 | 1 | 2 | 3 | 4 |
| 4. | Words run together when reading | 0 | 1 | 2 | 3 | 4 |
| 5. | Burning, stinging, watery eyes | 0 | 1 | 2 | 3 | 4 |
| 6. | Falling asleep when reading | 0 | 1 | 2 | 3 | 4 |
| 7. | Vision worse at the end of the day | 0 | 1 | 2 | 3 | 4 |
| 8. | Skipping or repeating lines when reading | 0 | 1 | 2 | 3 | 4 |
| 9. | Dizziness or nausea associated with near work | 0 | 1 | 2 | 3 | 4 |
| 10. | Head tilt or closing one eye when reading | 0 | 1 | 2 | 3 | 4 |
| 11. | Difficulty copying from the board | 0 | 1 | 2 | 3 | 4 |
| 12. | Reversals of letters like b's, d's, p's, q's | 0 | 1 | 2 | 3 | 4 |
| 13. | Avoidance of reading and near work | 0 | 1 | 2 | 3 | 4 |
| 14. | Omitting small words when reading | 0 | 1 | 2 | 3 | 4 |
| 15. | Writing uphill or downhill | 0 | 1 | 2 | 3 | 4 |
| 16. | Misaligning digits in columns of numbers | 0 | 1 | 2 | 3 | 4 |
| 17. | Reading comprehension declining over time | 0 | 1 | 2 | 3 | 4 |
| 18. | Inconsistent/poor sports performance | 0 | 1 | 2 | 3 | 4 |
| 19. | Holding reading material too close | 0 | 1 | 2 | 3 | 4 |
| 20. | Short attention span | 0 | 1 | 2 | 3 | 4 |
| 21. | Difficulty completing assignments in reasonable time | 0 | 1 | 2 | 3 | 4 |
| 22. | Saying "I can't" before trying | 0 | 1 | 2 | 3 | 4 |
| 23. | Avoiding sports and games | 0 | 1 | 2 | 3 | 4 |
| 24. | Difficulty with hand tools (scissors, keys) | 0 | 1 | 2 | 3 | 4 |
| 25. | Inability to estimate distances accurately | 0 | 1 | 2 | 3 | 4 |
| 26. | Tendency to knock things over on desk or table | 0 | 1 | 2 | 3 | 4 |
| 27. | Misplaces or loses papers, objects, belongings | 0 | 1 | 2 | 3 | 4 |
| 28. | Car sickness/motion sickness | 0 | 1 | 2 | 3 | 4 |
| 29. | Forget, poor memory | 0 | 1 | 2 | 3 | 4 |
| 30. | Very sensitive to lighting (too light/dark) when reading | 0 | 1 | 2 | 3 | 4 |

TOTAL: _____

Total scores above 30 or any one question above "3" could indicate potential vision problem

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