



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 chalkboard | 0 | 1 | 2 | 3 | 4 |
| 12. | Reversals of letters like "b's" + "d" or "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 | 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. | Forgetful, poor memory | 0 | 1 | 2 | 3 | 4 |
| 30. | Very sensitive to lighting (too light or dark) when reading | 0 | 1 | 2 | 3 | 4 |

Please do not fill in shaded areas

Pre-treatment totals	=					
Post-treatment totals	=					