



CHILD SYMPTOM QUESTIONNAIRE

Dear Parent:

This list of symptoms and observations of vision problems at school or home will help us understand how your child performs visually in his/her daily activities. With your child's help, please fill out this questionnaire.

NAME _____ CHILD'S AGE _____ DATE ___/___/___

Please check the appropriate column for each symptom listed.

READING, WRITING AND OTHER DESK WORK	often	sometimes	never
Eyes burn or feel strain after short periods of reading or close work			
Vision gets blurry when reading			
Gets headaches when reading			
Letters or words run together or move when reading			
Gets double vision when reading			
Fatigues quickly when reading			
Reading comprehension decreases over time			
Often loses place or omits words when reading			
Avoids reading or other close work			
Skips words or lines, has to re-read lines			
Holds material very close when reading			
GENERAL OBSERVATIONS ABOUT BEHAVIOR	often	sometimes	never
The eyes appear to cross or drift out			
Eyes appear to water or are red			
Dislikes or avoids tasks requiring sustained visual attention			
Frequent signs of frustration			
Tension during close work and reading			
SCHOOL PERFORMANCE	often	sometimes	never
Short attention span			
Reverses words, numbers or letters			
Difficulty copying from board or book			
Sloppy handwriting, excessive erasures			
Difficulty remembering spelling words			
GENERAL QUESTIONS	YES		NO
My child has had to repeat a year in school			
My child is having difficulty with reading			
My child is having difficulty with math			

