Symptom Checklist

Name_____ Date_____

Please answer 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.	Burning, stinging, watery eyes	0	1	2	3	4
5.	Rubbing or blinking of eyes	0	1	2	3	4
6.	Words run together when reading	0	1	2	3	4
7.	Falling asleep when reading	0	1	2	3	4
8.	Skipping or repeating lines when reading	0	1	2	3	4
9.	Difficulty copying from the chalkboard	0	1	2	3	4
10.	Head tilt or closing one eye when reading	0	1	2	3	4
11.	Reversals of letter like b,d,p,q	0	1	2	3	4
12.	Omitting small words when reading	0	1	2	3	4
13.	Reading comprehension declining over time	0	1	2	3	4
14.	Inconsistent/poor sports performance	0	1	2	3	4
15.	Holding reading material too close	0	1	2	3	4
16.	Short attention span	0	1	2	3	4
17.	Difficulty completing assignments in reasonable time	0	1	2	3	4
18.	Avoiding sports and games	0	1	2	3	4
19.	Car sickness/motion sickness	0	1	2	3	4
20.	Forgetful, poor memory	0	1	2	3	4

For Office Use Only	0	1	2	3	4	Total
Pre-Treatment Totals						
Post-Treatment Totals						