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.	Restricted field of vision	0	1	2	3	4
2.	Inability to completely close eyes	0	1	2	3	4
3.	Difficulty or pain moving or turning eyes	0	1	2	3	4
4.	Wandering eye	0	1	2	3	4
5.	Double vision	0	1	2	3	4
6.	Blurred vision, distance viewing	0	1	2	3	4
7.	Blurred vision, near viewing	0	1	2	3	4
8.	Slow to shift focus, near to far to near	0	1	2	3	4
9.	Pulling or tugging sensation around the eye	0	1	2	3	4
10.	Head turn or tilt	0	1	2	3	4
11.	Covering, closing one eye	0	1	2	3	4
12.	Disorientation	0	1	2	3	4
13.	Bothered by movement around you	0	1	2	3	4
14.	Bothered by noises in environment	0	1	2	3	4
15.	Light sensitivity	0	1	2	3	4
16.	Discomfort when reading	0	1	2	3	4
17.	Unable to sustain near work/reading for adequate periods	0	1	2	3	4
18.	Loss of place while reading	0	1	2	3	4
19.	Eyes get tired while reading	0	1	2	3	4
20.	Headaches	0	1	2	3	4
21.	Easily distracted, decreased attention or concentration ability	0	1	2	3	4
22.	Difficulty remembering what has been read	0	1	2	3	4
23.	Loss of balance	0	1	2	3	4
24.	Poor eye-hand coordination	0	1	2	3	4
25.	Poor handwriting	0	1	2	3	4
26.	Poor posture	0	1	2	3	4
27.	Dizziness	0	1	2	3	4
28.	Poor coordination/clumsiness	0	1	2	3	4

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