VISION THERAPY CENTER

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Visual Symptom Survey

Student's Name: _____ Age: _____ Grade: _____ Date: _____

Please put an "X" in the column that best shows how often this happens to your child.

How often does this happen?	ALWAYS	FREQUENT	OCCASIONAL	SELDOM	NEVER
1. Headaches with reading or writing					
2. Words run together or blur when reading					
3. Eyes burn, itch, or water					
4. Loses place while reading					
5. Head tilt or closes one eye when reading					
6. Hard to copy from the board					
7. Doesn't like reading or writing					
8. Leaves out small words when reading					
9. Hard to write in a straight line					
10. Misaligns digits/columns of numbers					
11. Poor reading comprehension					
12. Holds book very close					
13. Hard to pay attention when reading					
14. Hard to complete assignments on time					
15. Gives up easily					
16. Clumsy, bumps into things					
17. Homework takes too long					
18. Daydreams					
19. Forgetful/poor memory					

Number of marks in each column	_____	_____	_____	_____	_____
Multiply # of marks by	(x 4)	(x 3)	(x 2)	(x 1)	(x 0)
Score for each column	_____	_____	_____	_____	_____

TOTAL SCORE _____

This checklist is an excellent screening tool.
The effectiveness in identifying at-risk children has been documented with research.

If your child's score is more than 20, he or she has greater than an 80% chance of having a vision problem that is interfering with learning.