

Children's Visual Symptoms Survey

Patient Name: _____ Date: _____

	Possible Subjective Symptoms	Never	Not Very Often	Some times	Fairly Often	Always
1.	Do your eyes feel tired when reading or doing close work?					
2.	Do your eyes feel uncomfortable (hurt or pull) when reading or doing close work?					
3.	Do you have headaches when reading or doing close work?					
4.	Do you feel sleepy when reading or doing close work?					
5.	Do you lose concentration when reading or doing close work?					
6.	Do you have trouble remembering what you have read?					
7.	Do you have double vision when reading or doing close work?					
8.	Do you feel like you read slowly?					
9.	Do you see words move, jump, swim or appear to float on the page when reading or doing close work?					
10.	Do you notice the words blurring or coming in and out of focus when reading or doing near work?					
11.	Do you lose your place while reading or doing close work?					
12.	Do you have to reread the same line of words when reading?					
13.	Do you skip lines when reading?					
14.	Do you reverse letters?					
15.	Do you have trouble copying from the board to your paper?					
16.	Do you have problems understanding what you read?					
17.	Do you act impulsively or lose your attention?					
	Total Score =	__ x 0	__ x 1	__ x 2	__ x 3	__ x 4

Does your child have any learning disabilities? Yes No (if yes, explain) _____

Does your child read on or above grade level? Yes No

Subjective

Objective

Fixation Test	Acc.	Marg.	Inadeq.	Acc.	Marg.	Inadeq.
Break	(1-3)	(4-7)	(>8)	(1-3)	(4-7)	(>8)
Recovery	(3-6)	(7-10)	(>11)	(3-6)	(7-10)	(>11)

Subjective

Red/Green NPC	Acc.	Marg.	Inadeq.
Break	(1-3)	(4-7)	(>8)
Recovery	(3-6)	(7-10)	(>11)