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Symptom Checklist

Name: _____ Date: _____

Please complete 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.	Words run together when reading	0	1	2	3	4
5.	Burning, stinging, watery eyes	0	1	2	3	4
6.	Falling asleep when reading	0	1	2	3	4
7.	Vision worse at the end of the day	0	1	2	3	4
8.	Skipping or repeating lines when reading	0	1	2	3	4
9.	Dizziness or nausea associated with near work	0	1	2	3	4
10.	Head tilt or closing one eye when reading	0	1	2	3	4
11.	Difficulty copying from the chalkboard	0	1	2	3	4
12.	Reversals of letters like b's, d's, p's, and q's	0	1	2	3	4
13.	Avoidance of reading and near work	0	1	2	3	4
14.	Omitting small words when reading	0	1	2	3	4
15.	Writing uphill or downhill	0	1	2	3	4
16.	Misaligning digits in columns of numbers	0	1	2	3	4
17.	Reading comprehension declining over time	0	1	2	3	4
18.	Inconsistent/poor sports performance	0	1	2	3	4
19.	Holding reading material too close	0	1	2	3	4
20.	Short attention span	0	1	2	3	4
21.	Difficulty completing assignments in reasonable time	0	1	2	3	4
22.	Saying "I can't" before trying	0	1	2	3	4
23.	Avoiding sports and games	0	1	2	3	4
24.	Difficulty with hand tools (scissors, keys)	0	1	2	3	4
25.	Inability to estimate distances accurately	0	1	2	3	4
26.	Tendency to knock things over on desk or table	0	1	2	3	4
27.	Misplaces or loses papers, objects, belongings	0	1	2	3	4
28.	Car sickness/motion sickness	0	1	2	3	4
29.	Forget, poor memory	0	1	2	3	4
30.	Very sensitive to lighting (too light or dark) when reading	0	1	2	3	4

Pre-treatment Totals =						
Post-treatment Totals =						