Patient: _____ Date:_____

Symptom Sheet (School-Aged Child)

With your child's help, please circle the correct response.

Reading, Writing and Other Desk Work:

Yes No Eyes burn or feel strained after short periods of reading or other close work
Yes No Vision gets blurry when reading
Yes No Gets headaches when reading
Yes No Letters or words run together or move when reading
Yes No Gets double vision when reading
Yes No Fatigues quickly when reading
Yes No Reading comprehension decreases over time
Yes No Often loses place or omit words when reading
Yes No Avoids reading or other close work
Yes No Skips words or lines or have to re-read lines
Yes No Holds material very close when reading

General Observations About Behavior:

Yes No Eyes appear to cross or drift out
Yes No Eyes appear to water or to be bloodshot
Yes No Dislikes or avoids tasks requiring sustained visual attention
Yes No Frequent signs of frustration
Yes No Tension during close work and reading

School Performance:

Yes No Short attention span
Yes No Reverses words, numbers or letters
Yes No Difficulty copying from board to book
Yes No Sloppy handwriting, excessive erasures
Yes No Difficulty remembering spelling of words

General Questions:

Yes No Has had to repeat a year in school
Yes No Is having difficulty with reading
Yes No Is having difficulty with math
____ ____ TOTAL SCORE

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