

**Strasburg Vision and Learning Center
717-687-8141**

Children's 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, 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. Burning, stinging, watery eyes	0	1	2	3	4
5. Rubbing or blinking of eyes	0	1	2	3	4
6. Words run together when reading	0	1	2	3	4
7. Falling asleep when reading	0	1	2	3	4
8. Skipping or repeating lines when reading	0	1	2	3	4
9. Difficulty copying from the chalkboard	0	1	2	3	4
10. Head tilt or closing of one eye when reading	0	1	2	3	4
11. Reversals of letter like b,d,p,q	0	1	2	3	4
12. Omitting small words when reading	0	1	2	3	4
13. Reading comprehension declining over time	0	1	2	3	4
14. Inconsistent/poor sports performance	0	1	2	3	4
15. Holding reading material/ video games too close	0	1	2	3	4
16. Short attention span	0	1	2	3	4
17. Difficulty completing assignments in reasonable time	0	1	2	3	4
18. Avoiding sports and games	0	1	2	3	4
19. Car sickness/motion sickness	0	1	2	3	4
20. Forgetful, poor memory	0	1	2	3	4

FOR OFFICE USE ONLY!	0	1	2	3	4	Total
Pre-Treatment Totals						
Post-Treatment						