30 SYMPTOM CHECK LIST

PATIENT'S NAME____DATE_____/_____/_____

Check the column which best represents the occurrence of each symptom (parent & teacher can both complete it)

	Never	Seldom	Occasionally	Frequently	Always
Blur when looking at near					
Double Vision					
Headaches with near work					
Words run together when reading					
Burning, itching, watery eyes					
Falls asleep when reading					
Sees worse at the end of the day					
Skips / repeats lines when reading					
Dizziness / nausea with near work					
Head tilts /closes one eye when reading					
Difficulty copying from the board					
Avoids near vision work / reading					
Omits small words when reading					
Writes up / down hill					
Misaligns digits / columns of numbers					
Reading comprehension is down					
Poor / inconsistent performance in sports					
Holds reading material too close					
Trouble keeping attention					
Difficult completing assignments on time					
Always says "I can't" before trying					
Avoids sports / games					
Poor hand / eye coordination (poor handwriting)					
Does not judge distance accurately					
Clumsy, knocks things over					
Does not use his / her time well					
Does not make change well					
Loses belongings / things					
Forgetful / poor memory					
Car / Motion sick					