

Patient: _____ Date: _____

Symptom Sheet (School-Aged Child)

With your child's help, please check 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**