# VISION & LEARNING POST VISION THERAPY SYMPTOM QUESTIONNAIRE

Child's Name _____ Parent's Name _____ Date Completed _____

**As you/your child reaches his or her visual goals, please re-evaluate** whether the following signs and behaviors are noticed when reading or doing close work or in the classroom. Please check either: never, infrequently, sometimes, fairly often, or always for each question.

| Symptom | Never | Infre-quently | Some-times | Fairly often | Always |
|---|---|---|---|---|---|
| 1. Do your eyes feel tired or uncomfortable during or after reading or doing close work? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Do your eyes ever hurt or feel sore during or after reading or doing close work? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Do you get headaches during or after reading or doing close work? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Do you notice a "pulling" feeling around your eyes when reading or doing close work? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Do you feel sleepy when reading or doing close work? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Do you lose concentration or are easily distracted when reading or doing close work? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Do you have trouble remembering what you read? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Do you notice double vision when reading or doing close work or looking at the board? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Do you read slowly? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Do you avoid reading? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Do the words blur or come in and out of focus when reading, doing close work, or looking at the board? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Do you lose your place or re-read the same line while reading or doing close work or looking up at the board across room? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Do you notice blurry distance vision (on board across room) after reading or doing close work (momentarily or sustained)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Do you make reversal errors when reading (was for saw, on for no) or writing (b for d)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Do you overlook small details (read "beak" for "break") or math symbols ("-" for "+")? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Do you have difficulty copying written material (e.g. from the board)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. Do you have poor printing or handwriting? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. Do you have difficulty finishing school assignments in a timely manner? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20. Do you misalign digits or columns when doing math assignments? | ☐ | ☐ | ☐ | ☐ | ☐ |

TOTAL SCORE_____ (Score 0 for Never; 1 for Infrequently, 2 for Sometimes, 3 for Fairly Often, 4 for Always)

(***PLEASE SEE SECOND PAGE)

# VISION & LEARNING POST VISION THERAPY SYMPTOM QUESTIONNAIRE

Please share with us your experience with vision therapy in our office.

1. How many vision therapy units did you complete? _____
2. Did you attend all of your vision therapy sessions? _____
3. Do you feel that vision therapy has addressed your visual concerns? _____
   _____
4. What academic areas have you noted changes in? _____
   _____
5. What non-academic areas have you noted changes in? (eg. Sports performance, self-confidence, etc.) _____
   _____
6. Did you complete home vision therapy activities during your program? How often? _____
   _____

Do we have your permission to share the above answers with another patient interested in vision therapy? No names or personal identifying information will be used. If so, please sign below:

_____ _____

Parent or Guardian Signature Date