VISUAL PROCESSING OPTOMETRY

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Name_____ Date_____

Please assign a value between 0 and 4 for each symptom and total at the bottom.
0 = never or nonexistent; 1 = seldom; 2 = occasionally; 3 = frequently; 4 = always

Item	Symptom	
1.	Blurred vision at far and/or near	_____
2.	Double vision	_____
3.	Burning, stinging, water eyes	_____
4.	Car sickness/motion sickness	_____
5.	Can't make or sustain eye contact	_____
6.	Eyes do not look aligned (turn in or out)	_____
7.	Appears to be lazy	_____
8.	Can only do 1 thing at a time	_____
9.	Performance not up to potential	_____
10.	Short attention span	_____
11.	Avoiding sports and games	_____
12.	Clumsiness	_____
13.	Poor handwriting	_____
14.	Reversals when writing	_____
15.	Problems with visual directions or reading maps	_____
16.	Difficulty completing assignment in reasonable time	_____
17.	Head tilt, distorted posture or closes one eye when reading	_____
18.	Words run together when reading	_____
19.	Falling asleep when reading	_____
20.	Skipping or repeating lines when reading	_____
21.	Reversals when reading (eg. was for saw, on for no)	_____
22.	Avoidance of reading and near work	_____
23.	Omitting or confusing small words when reading	_____
24.	Poor reading comprehension	_____
25.	Holding reading material too close	_____
26.	Transposition of numbers (e.g. 12 for 21)	_____
27.	Loss of place when reading	_____
28.	Uses finger or a marker when reading	_____
29.	Unable to read for long periods of time	_____
	Total	_____

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