

Child Quality of Life Survey

Patient Name: _____ Date: _____

Person Filling out this survey: _____ Relation to Patient: _____

Place a check in the box that corresponds to the frequency of each symptom your child has.

Symptoms	Never	Seldom (1-2x/mo)	Occasionally (3-5x/mo)	Frequently (2-3x/wk)	Always (4-5x/wk)
Blur when looking at near	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches with near work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Words run together when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning, itchy, watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls asleep when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees worse at the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skips/repeats lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy/Nausea with near work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head tilt/closes one eye when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty copying from far (i.e. chalkboard) to near (i.e. paper)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoids near work/reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Omits small words when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes up/down hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misaligns digits/columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading comprehension down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor/inconsistent in sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Holds reading material too close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble keeping attention on reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty completing assignments on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always says "I can't" before trying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoids sports/games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor eye/hand coordination (i.e. handwriting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not judge distance accurately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clumsy, knocks things over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not use his/her time well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not count or make change well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses belongings/things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car/motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetful/poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office Use Only	Total	_____	_____	_____	_____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING IN YOUR CHILD:

	<u>Yes</u>	<u>No</u>	<u>If yes, describe:</u>
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent sties	<input type="checkbox"/>	<input type="checkbox"/>	
Frowning/Facial distortions when reading	<input type="checkbox"/>	<input type="checkbox"/>	
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent blinking	<input type="checkbox"/>	<input type="checkbox"/>	
Closing or covering one eye	<input type="checkbox"/>	<input type="checkbox"/>	Which eye? _____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	
Head close to paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	How close? _____
Prefers being read to	<input type="checkbox"/>	<input type="checkbox"/>	
Tilts head when reading	<input type="checkbox"/>	<input type="checkbox"/>	Direction of tilt? _____
Tilts head when writing	<input type="checkbox"/>	<input type="checkbox"/>	Direction of tilt? _____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	
Confuses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	
Reverses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	
Confuses right and left	<input type="checkbox"/>	<input type="checkbox"/>	
Vocalizes when reading silently	<input type="checkbox"/>	<input type="checkbox"/>	
Reads slowly	<input type="checkbox"/>	<input type="checkbox"/>	
Uses finger as a marker	<input type="checkbox"/>	<input type="checkbox"/>	
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	
Writes neatly but slowly	<input type="checkbox"/>	<input type="checkbox"/>	
Does not support paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	
Awkward or immature pencil grip	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent erasures	<input type="checkbox"/>	<input type="checkbox"/>	
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty recognizing same word on different page	<input type="checkbox"/>	<input type="checkbox"/>	
Poor word attack skills	<input type="checkbox"/>	<input type="checkbox"/>	
Remembers better when hears than sees it	<input type="checkbox"/>	<input type="checkbox"/>	
Responds better orally than by writing	<input type="checkbox"/>	<input type="checkbox"/>	
Seems to know material, but tests poorly	<input type="checkbox"/>	<input type="checkbox"/>	
Poor large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with scissors / small hand tools	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty catching / hitting a ball	<input type="checkbox"/>	<input type="checkbox"/>	

List any other complaints your child makes concerning his/her vision:
