Brodie Sensory Learning and Vision Therapy
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Vision Symptom Survey

Name: ____ Date: ___/___/___

Instructions: Please answer the following questions about how your eyes or your child's eyes feel when reading or doing close work.

		Never	(not very often) Infrequently	Sometimes	Fairly often	Always
1.	Eyes feel tired when reading or doing close work					
2.	Eyes feel uncomfortable when reading or doing close work					
3.	Headaches when reading or doing close work					
4.	Feel sleepy when reading or doing close work					
5.	Lose concentration when reading or doing close work					
6.	Have trouble remembering what has been read					
7.	Double vision when reading or doing close work					
8.	Words move, jump, swim or appear to float on the page when reading or doing close work					
9.	Read slowly					
10.	Eyes hurt when reading or doing close work					
11.	Eyes feel sore when reading or doing close work					
12.	Feel a "pulling" feeling around eyes when reading or doing close work					
13.	Words blur or come in and out of focus when reading or doing close work					
14.	Lose place while reading or doing close work					
15.	Need to re-read the same line of words when reading					
		___x0	___x1	___x2	___x3	___x4

TOTAL SCORE: _____________