Quality of Life Survey

Please put an "X" in the column that best shows how often this happens to your child.

How often does this happen?	**Never 0**	**A little 1**	**Sometimes 2**	**A lot 3**	**Always 4**
Headaches with reading or writing					
Words slide together or get blurry when reading					
Reads below grade level					
Loses place while reading					
Head tilt or closes an eye when reading					
Hard to copy from the board					
Doesn't like reading or writing					
Leaves out small words when reading					
Hard to write in a straight line					
Burning, itching, or watery eyes					
Hard to understand what he/she has read					
Holds book very close					
Hard to pay attention when reading					
Hard to finish assignments					
Gives up easily (says "I can't" before trying)					
Bumps into things, knocks things over					
Homework takes too long					
Daydreams					
In trouble for being off task at school					

(over)

Scoring

	Never	A little	Sometimes	A lot	Always
Number of total marks in each column					
Multiply total marks in each column by:	X 0	X 1	X 2	X 3	X 4
Score for each column					
Total score for all columns_____*					

*Total score greater than 20 indicates the child is at risk for a vision-based learning problem.
Further evaluation by a developmental optometrist is recommended.

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