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Adult Symptom Checklist

Name: _____ Date: _____

Please complete this questionnaire. After each symptom listed, circle the number that best describes how often you experience that particular problem.

		NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
1	Eye strain or pain	0	1	2	3	4
2	Eye fatigue or eye rubbing	0	1	2	3	4
3	Blurry vision at near or far distance	0	1	2	3	4
4	Double vision	0	1	2	3	4
5	Headache after visual task	0	1	2	3	4
6	Dizziness or nausea after visual task	0	1	2	3	4
7	Light sensitivity	0	1	2	3	4
8	Poor depth perception	0	1	2	3	4
9	Bumps into objects/clumsiness	0	1	2	3	4
10	Can't tolerate "visually-busy" places	0	1	2	3	4
11	Uncomfortable while driving/riding in the car	0	1	2	3	4
12	Difficulty adjusting focus between near and far	0	1	2	3	4
13	Poor balance or unsteady walking	0	1	2	3	4
14	Closing an eye or head tilt	0	1	2	3	4
15	Skipping words or lines when reading	0	1	2	3	4
16	Cannot read long before fatiguing	0	1	2	3	4
17	Poor comprehension or slow when reading	0	1	2	3	4
18	Poor memory	0	1	2	3	4
19	Decreased ability to participate in sports/hobbies	0	1	2	3	4

TOTAL: _____

Total scores above 15 or any one question above "3" raise suspicion about a potential vision problem.