Vision and Learning Screener

Name_____ **Age**_____ **Grade**_____

Teacher_____ **School**_____

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
1. Headaches with reading or writing					
2. Words slide together or get blurry when reading					
3. Reads below grade level					
4. Loses place while reading					
5. Head tilt or closes an eye when reading					
6. Hard to copy from the board					
7. Doesn't like reading or writing					
8. Leaves out small words when reading					
9. Hard to write in a straight line					
10. Burning, itching, or watery eyes					
11. Hard to understand what he/she has read					
12. Holds book very close					
13. Hard to pay attention when reading					
14. Hard to finish assignments on time					
15. Gives up easily (says "I can't" before trying)					
16. Bumps into things, knocks things over					
17. Homework takes too long					
18. Daydreams					
19. In trouble for being off task at school					
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 pediatric optometrist is recommended.**