ADULT PRE-SCREENING FORM

THE OPTOMETRY CENTER
FOR VISION THERAPY

Date:_____

NAME _____

Please rate the following signs & symptoms according to your current observations and/or experiences about how your eyes feel. Indicate the frequency of these signs and symptoms using the following number scale:

*Score **0** for Never, **1** for Infrequently, **2** for Sometimes, **3** for Fairly Often, **4** for Always*
*Legend: N= **Never**, I= **Infrequently**, S= **Sometimes**, FO= **Fairly Often**, A= **Always***

Signs and Symptoms	N	I	S	FO	A
1. Eyes feel tired while reading or doing close work					
2. Eyes feel uncomfortable while reading or doing close work					
3. Headaches when reading or doing close work					
4. Feels sleepy when reading or doing close work					
5. Loss of concentration when reading or doing close work					
6. Trouble remembering what you read					
7. Reports double vision when reading or doing close work					
8. Words move, jump, swim, or appear to float on the page					
9. Slow reader					
10. Eyes hurt when reading or doing close work					
11. Eyes feel sore when reading or doing close work					
12. "Pulling feeling" around eyes when reading or doing close work					
13. Words blur or go in and out of focus when reading or doing close work					
14. Loss of place while reading or doing close work					
15. Re-reads the same line of words or omits words when reading					
16. Reversal errors when reading (was for saw, on for no) or writing (b for d)					
17. Transposes letters or numbers (21 for 12)					
18. Difficulties copying from the board/book/paper/computer screen					
19. Poor printing or handwriting					
20. Avoidance of reading					
21. Difficulties completing work/other tasks in a timely manner					
22. Misaligns digits or columns when doing math					
23. Seems to be clumsy or knock things over					
24. Overlooks small details (reads beak for break) or misreads (- for +)					
25. Short attention span/easily distracted when reading/doing tasks					
column sub-totals					
(add column sub-totals to get the Total Score) **Total Score**					

****A Total Score equal to or greater than 16 warrants a consultation with a Developmental Optometrist specializing in the diagnosis and treatment of vision system deficiencies.**