SCREENING QUESTIONNAIRE

Binocular Vision Dysfunction / Vertical Heterophoria

For Ages 9-13

PA

Child's Name _____ Parent/Guardian's Name _____ Date _____

Phone Number _____ Email _____

Directions: ***Children - answer these questions together with your Parent/Guardian.*** For each of the following questions, please check the answer that best describes your situation. If you wear glasses or contact lenses, answer the questions assuming that you are wearing them.

Always = every day **Frequently** = at least once per week

Occasionally = less than once per week **Never** = never

		ALWAYS	FREQUENTLY	OCCASIONALLY	NEVER
1	Do you have headaches or stomach aches or do you get nervous/anxious at school?				
2	While reading or watching video in a car, do you get a headache or stomach ache or feel unwell?				
3	Do you get sick to your stomach or nauseous on swings or circular rides?				
4	Do you have difficulty playing sports, or doing gymnastics or dance?				
5	Do you have trouble catching baseballs or footballs or Frisbees?				
6	When you are walking, do you bump into people or furniture or door frames?				
7	Are you anxious or nervous?				
8	Does it take you a long time to finish your homework?				
9	Do you have to read the same thing a couple of times to really understand it?				
10	When reading, do you skip lines or lose your place **OR** do you use a guide (finger, ruler or a piece of paper) to help you keep your place?				
11	When you read, does it look like the letters are moving **OR** does it seem like words are bumping into each other?				
12	Do bright lights hurt your eyes?				
13	Do you close or cover one eye to make it easier to see?				
14	Do you ever see two of everything (double vision)?				
15	When reading or working on the computer or electronic device, do your eyes feel tired or does your vision get blurry?				
16	When looking at the blackboard at school, do your eyes feel tired or does your vision get blurry?				
	TOTALS				

On an average day, how much are you bothered by symptoms listed here?

Rate each symptom from 0 - 10 0 = None of that symptom 10 = Worst

	None										Worst
Dizziness	0	1	2	3	4	5	6	7	8	9	10
Nausea	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10

	None										Worst
Neckache	0	1	2	3	4	5	6	7	8	9	10
Unsteady when walking	0	1	2	3	4	5	6	7	8	9	10
Sensitivity to light	0	1	2	3	4	5	6	7	8	9	10
Reading difficulty	0	1	2	3	4	5	6	7	8	9	10
Sound Sensitivity	0	1	2	3	4	5	6	7	8	9	10

Compared to the way I felt before I came to Vision Specialists:

If you are feeling better, by what percentage have you improved? _____**% Improved**

Please record any additional symptoms your child may be experiencing or specific concerns that you may have about your child's current prescription:

_____

_____

_____

_____

_____

_____

NVM NETWORK NeuroVisual Medicine NETWORK

This questionnaire is designed to screen for those who may have difficulty with vision alignment. The information obtained herein is considered a preliminary result only and does not diagnose or constitute confirmation of any vision problems. It is not a substitute for a NeuroVisual examination. Since vision changes can occur without visible indications, most eye care professionals and medical authorities recommend a vision exam annually.