DAKOTA VISION CENTER
Best care in sight.

Name of child: _____ **DOB:** _____
Age: _____

Please answer the below questions as experienced with glasses or contacts (if they've been prescribed).

Please indicate with an 'X' on how often the following symptoms are experienced by the patient:

Question	Never	Seldom	Occasionally	Frequently	Always
Headaches with near work					
Words run together while reading					
Burning, itchy, or watery eyes					
Skipping/repeating lines while reading					
Tilting head or closing one eye when reading					
Difficulty copying from a chalkboard					
Avoiding near work or reading					
Omitting small words when reading					
Writing uphill or downhill					
Misaligning digits/columns of numbers					
Poor reading comprehension					
Holding books or near work very close to eyes					
Short attention span with near work					
Difficulty completing assignments on time					
Saying "I can't" before trying something					
Clumsiness and knocking things over					
Poor use of time					
Losing belongings or misplacing things					
Forgetting things					