Lifestyle Checklist

Name: _____ Date: _____

Please assign a value between 0 and 4 for each symptom.

0= never or non-existent / 1=seldom / 2=occasionally / 3=frequently / 4=always

1	**Blurred vision at near**	
2	**Double vision**	
3	**Headaches with near work**	
4	**Words run together when reading**	
5	**Burning, stinging, watery eyes**	
6	**Falling asleep when reading**	
7	**Vision worse at the end of the day**	
8	**Skips or repeats lines when reading**	
9	**Dizziness or nausea with near work**	
10	**Head tilt or closing one eye when reading**	
11	**Difficulty copying from the board**	
12	**Avoidance of reading and near work**	
13	**Omitting small words when reading**	
14	**Writing uphill or downhill**	
15	**Mis-aligning digits in columns of numbers**	
16	**Reading comprehension down**	
17	**Inconsistent/poor sports performance**	
18	**Holds reading material too close**	
19	**Has trouble staying on-task when reading**	
20	**Difficulty completing assignments in reasonable time**	
21	**Says "I can't" before trying**	
22	**Avoiding sports and games**	
23	**Poor eye-hand coordination, poor handwriting**	
24	**Poor at estimating distances accurately**	
25	**Clumsy, knock things over on desk or table**	
26	**Difficulty with time management**	
27	**Difficulty with money concepts, making change**	
28	**Loses papers, objects, belongings**	
29	**Car sickness/motion sickness**	
30	**Forgetful, poor memory**	