

ESTABLISHED SYMPTOM CHECKLIST FOR UNDER 5

Appointment Date: ____ / ____ / ____

Full Legal Name: _____ Date of Birth: ____ / ____ / ____ Age: _____

Reason for today's visit: _____

Any changes/concerns since last visual evaluation? _____

How often does each symptom occur?

*Symptoms are organized into areas of vision they may affect the most, however, **many** symptoms can be related to several different visual problems.*

If you feel this symptom checklist is not appropriate for your child, please feel free to only fill out what is applicable or write us a brief summary of your child and their unique abilities or struggles.

Never (N)	Occasionally (O)	Frequently (F)	Always (A)
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Visual Comfort

Eyes hurt				
Headaches				
Rubs eyes				
Dizziness, or nausea				
Carsickness/motion sickness				
Bothered by light				

Refractive Status and Focus (Accommodation)

Squints				
Difficulty learning to copy				
Dislikes/avoids close activities, such as coloring				
Fatigues easily during visual tasks				
Head close to paper when looking at books				

Eye Tracking (Ocular Motility)

Does not follow moving objects with eyes				
Turns head or body to follow objects/people				

Eye Teaming (Binocularity)

Squints, closes, or covers one eye				
One eye turns (in, out, up, or down) at any time				
Tilts or turns head to one side				
Poor depth perception				
Tendency to knock things over, spatially off when judging distances				

	N	O	F	A
Difficulty walking up or down steps				
Flinches or closes eyes when object (e.g., a ball) comes toward them				
Dislikes 3-D movies				

Visually Guided Activities

Difficulty with tying shoes				
Difficulty engaging in reciprocal play				
Dislikes puzzles, legos, intricate fine motor activities				
Body movements such as walking, climbing up/down stairs, jumping, and running are not smooth and fluid (as appropriate for their age)				
Does not engage in developmentally appropriate motor activities (e.g., riding a trike or scooter)				
Trips or stumbles				

Central-Peripheral Integration

Seems to look past you				
Tendency to knock things over on desk or table				
Easily overwhelmed by chaotic visual environments				
Is not visually curious about their environment and objects in their environment				

Visual Information Processing

Difficulty following verbal instructions				
Performance not up to potential yet				

Appearance of the Eyes

Reddened eyes or lids				
Excessive tearing of eyes				
Eye turns in, out, up and/or down				
Blinks excessively				
Frequent sties				