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LIFESTYLE CHECKLIST

Name: _____
Date: _____

PRE SCORE: _____ POST SCORE: _____

Please assign a value between 0 and 3 for each symptom.
0= never or non-existent/1=occasionally/2=frequently/3=always

1	**Blurred Vision at near**	
2	**Double vision**	
3	**Headaches associated with near work**	
4	**Words run together when reading**	
5	**Burning, stinging, watery eyes**	
6	**Falling asleep when reading**	
7	**Vision worse at end of the day**	
8	**Skipping or repeating lines when reading**	
9	**Dizziness or nausea associated with near work**	
10	**Head tilt or closing one eye when reading**	
11	**Difficulty copying from a chalkboard or whiteboard**	
12	**Avoidance of reading or near work**	
13	**Omitting small words when reading**	
14	**Writing uphill or downhill**	
15	**Misaligning digits in columns of numbers**	
16	**Reading comprehension declining over time**	
17	**Inconsistent/poor sports performance**	
18	**Holding reading material too close**	
19	**Short attention span**	
20	**Difficulty completing assignments in reasonable time**	
21	**Difficulty with left/right or reversing letters and numbers**	
22	**Avoiding sports and games**	
23	**Difficulty with using pencil or scissors**	
24	**Inability to estimate distances accurately**	
25	**Tendency to knock things over on a desk or table**	
26	**Difficulty with mathematical concepts**	
27	**Misplaces or loses papers, objects, belongings**	
28	**Difficulty with time management**	
29	**Car sickness/motion sickness**	
30	**Forgetful, poor memory**	