SCREENING QUESTIONNAIRE

Binocular Vision Dysfunction / Vertical Heterophoria

For Ages 4-8

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

Phone Number _____ Email _____

Directions: ***Children - answer these questions together with your Parent/Guardian.*** For every question, please answer YES or NO. If you wear glasses, answer the questions assuming that you are wearing them.

DOES YOUR CHILD:		**YES**	**NO**
A	have difficulty reading or learning **OR** skip letters or words or lines **OR** misread words or reverse numbers or words **OR** lose their place often while reading?		
B	have poor handwriting – poor letter sizing (too big or too small), poor spacing, writing lines with an upward or downward slant?		
C	avoid near activities **OR** do they act out after 5-10 minutes if they must perform near activities?		
D	sit very close to the TV / monitor / electronic devices **OR** hold toys very close to their face to see them?		
E	have difficulty identifying shapes, colors, letters, numbers and common images that are age appropriate?		
F	walk with difficulty (do they sway, trip or fall **OR** bump into objects or people) **OR** avoid climbing on furniture or outdoor playscapes?		
G	have trouble seeing the board, or seeing up close?		
H	have difficulty catching or kicking a ball?		
I	have headaches or stomach aches at school, pre-school or when away from home?		
J	have light sensitivity (closes/covers eyes in bright light) **OR** not like bright places?		
K	close or cover one eye when doing up close activities?		
L	have nervousness or anxiety **OR** get startled often **OR** is clingy in stores?		
M	squint or blink or make faces to "see"?		
	TOTALS		

Parent/Guardian: Has your child ever been diagnosed with:

	YES	NO		YES	NO
Learning Disability (LD)?			Migraines or headache?		
Dyslexia?			Traumatic brain injury or concussion?		
Torticollis?			Does your child blink his/her eyes a lot/much more than most children?		
Lazy eye?			Are your child's verbal skills far ahead of his/her reading skills?		
ADD/ADHD?			Has your child ever had an eye operation?		

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

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

This questionnaire is designed to screen for children who may be having symptoms due to a vision misalignment.

Using questions A through M on the front of this page, consider an evaluation by a NeuroVisual Specialist if **FOUR or more questions were answered YES.**

Fax this document to **(248) 499-6372** or email it to **support@VSofM.com** and we will contact you; or call **(248) 258-9000** to schedule an appointment.

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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.

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