19 Item COVD-QOL Checklist Questionnaire

Check the column which best represents the occurrence of each symptom

Name _____ **Date**_____

		Never 0	Seldom 1	Occasional 2	Frequently 3	Always 4
1. Headaches with near work	A					
2. Words run together reading	B					
3. Burn, itch, watery eyes	B					
4. Skips/repeats lines reading	OM					
5. Head tilt/close one eye when reading	B					
6. Difficulty copying from chalkboard	A					
7. Avoids near work/reading	A					
8. Omits small words when reading	OM					
9. Writes up/down hill	O					
10. Misaligns digits/columns of numbers	OM					
11.Reading comprehension down	P					
12. Holds reading too close	A					
13. Trouble keeping attention on reading	P					
14. Difficulty completing assignments on time	*					
15. Always says "I can't" before trying	P					
16. Clumsy, knocks things over	O					
17. Doesn't use his/her time well	P					
18. Loses belongings/things	P					
19. Forgetful/poor memory	P					

A=Accommodation; B=Binocularity; O=Orientation; OM=Ocularmotor; P=Perception; *=All

Other Comments:

Completed By:_____

If you're concerned with your child's assessment results, feel free to include your name and email or phone number and submit the form. We'll be happy to connect with you to discuss their symptoms further.

This is the one I like: https://www.eagleeyevisiontherapy.com/symptom-assessment-lrvp