Developmental Vision Care, P.C.

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Developmental Optometrist

30 Question Predictive Checklist

Name _____ **Age** _____ **Grade** _____ **Date** ____/____/____

Completed by _____ **Relationship** _____

Address _____ **City**_____ **State** _____ **Zip** _____

Phone _____ **Email** _____

Current Eyecare Provider _____ **City** _____

Instructions: After you consider each question, mark the column that applies to the person you are assessing.	Never	Seldom	Occasional	Frequent	Always	Score
Blurred vision at near	0	1	2	3	4	
Double vision	0	1	2	3	4	
Headaches associated with near work	0	1	2	3	4	
Words run together when reading	0	1	2	3	4	
Burning, stinging, watery eyes	0	1	2	3	4	
Falling asleep when reading	0	1	2	3	4	
Vision worse at the end of the day	0	1	2	3	4	
Skipping or repeating lines when reading	0	1	2	3	4	
Dizziness or nausea associated with near work	0	1	2	3	4	
Head tilt or closing one eye when reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoidance of reading and near work	0	1	2	3	4	
Omitting small words when reading	0	1	2	3	4	
Writing uphill or downhill	0	1	2	3	4	
Misaligning digits in columns of numbers	0	1	2	3	4	
Reading comprehension declining over time	0	1	2	3	4	
Inconsistent/poor sports performance	0	1	2	3	4	
Holding reading material too close	0	1	2	3	4	
Short attention span	0	1	2	3	4	
Difficulty completing assignments in reasonable time	0	1	2	3	4	
Saying "I can't" before trying	0	1	2	3	4	
Avoiding sports and games	0	1	2	3	4	
Difficulty with hand tools-scissors, calculator, keys, etc.	0	1	2	3	4	
Inability to estimate distances accurately	0	1	2	3	4	
Tendency to knock things over on desk or table	0	1	2	3	4	
Difficulty with time management	0	1	2	3	4	
Difficulty with money concepts, making change	0	1	2	3	4	
Misplaces or loses papers, objects, belongings	0	1	2	3	4	
Car sickness/motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	

20 – 24 points = suspect **25 points or more = refer for care**

TOTAL SCORE

❒ I would like a complimentary telephone consultation.
The most convenient day and time to reach me is: _____

I give permission to Developmental Vision Care to share my information with other professionals that they feel would be beneficial in the evaluation and treatment of my condition.

Patient/Guardian Signature _____