Quality of Life Checklist (19-Item)

Name: _____ Date: _____ PRE / POST

Please assign a value between 0 and 4 for each symptom.
0= never or non-existent / 1=seldom / 2=occasionally / 3=frequently / 4=always

1	Headaches associated with near work	
2	Words run together when reading	
3	Burning, stinging, watery eyes	
4	Skipping or repeating lines when reading	
5	Head tilt or closing one eye when reading	
6	Difficulty copying from the chalkboard	
7	Avoidance of reading and near work	
8	Omitting small words when reading	
9	Writing uphill or downhill	
10	Mis-aligning digits in columns of numbers	
11	Reading comprehension declining over time	
12	Holding reading material too close	
13	Short attention span	
14	Difficulty completing assignments in reasonable time	
15	Saying "I can't" before trying	
16	Tendency to knock things over on desk or table	
17	Difficulty with time management	
18	Misplaces or loses papers, objects, belongings	
19	Forgetful, poor memory	