Vision and Learning Checklist

Name	Age	Grade	Date

Your responses will help us better understand your child, and address any concerns you have in areas that might also have a visual connection. Please respond to these questions using the following rating system.

0 = Never, **1** = Seldom, **2** = Occasionally, **3** = Frequently, **4** = Always

1. Do you have concerns about your child's reading abilities?
   0 **1** **2** **3** **4**
2. Does your child skip lines/words when reading?
   0 **1** **2** **3** **4**
3. Does your child struggle keeping their attention centered on reading?
   0 **1** **2** **3** **4**
4. Does your child have better comprehension when someone reads to him or her?
   0 **1** **2** **3** **4**
5. Is homework a struggle?
   0 **1** **2** **3** **4**
6. Does your child have difficulty completing assignments in a reasonable amount of time?
   0 **1** **2** **3** **4**
7. Do you have concerns with your child's reversals of letters/numbers?
   0 **1** **2** **3** **4**
8. Do you have concerns about your child's handwriting skills?
   0 **1** **2** **3** **4**
9. Does your child have frequent headaches or eye discomfort while reading or doing homework?
   0 **1** **2** **3** **4**
10. Does your child have trouble with motion sickness during trips in the car?
    0 **1** **2** **3** **4**