

**ADULT QUESTIONNAIRE**

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (m) \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_

<u>General Indicators</u> (Please circle all responses)	<b>Often</b>	<b>Some times</b>	<b>Rarely</b>	<b>Never</b>
<b>While reading do you:</b>				
Skip words <u>or</u> lines unintentionally?	O	S	R	N
Lose your place?	O	S	R	N
Repeat lines?	O	S	R	N
Use your finger, a marker <u>or</u> a ruler to keep your place?	O	S	R	N
Find it difficult to see the punctuation?	O	S	R	N
Move closer to <u>or</u> further away from the page to see better?	O	S	R	N
Read word by word as opposed to reading words in groups?	O	S	R	N
Have to reread for understanding?	O	S	R	N
Become fidgety / restless / easily distracted?	O	S	R	N
Feel words could go out of focus when you are tired?	O	S	R	N
Do you avoid reading whenever possible?	O	S	R	N
Do other people generally read faster than you?	O	S	R	N
Do you find spelling difficult?	O	S	R	N
Does your handwriting lack fluency and neatness?	O	S	R	N

<u>Eye Strain / Print Distortions</u>				
<b>While reading do:</b>				
The letters appear: O blurry O fuzzy O move slightly O double O distort				
O look 3D O have halos O have shadows O get lighter in colour (Please tick)				
You blink / squint / open your eyes wider to see better?	O	S	R	N
You rub your eyes?	O	S	R	N
You find it takes energy and effort to see the words?	O	S	R	N
Your eyes: O feel tired O strain O hurt O burn O itch O water O feel dry O become red (Please tick)				
You experience a sense of strain, frustration <u>or</u> find you look away from the page after?				
O 5 minutes O 15 minutes O 30 minutes O 60 minutes O 60+ minutes (Please tick)				
Experience headaches?	O	S	R	N
Do your eyes feel tired <u>or</u> strained: after watching television?	O	S	R	N
: after using the computer?	O	S	R	N

<u>Light Sensitivity (Photophobia)</u>	Often	Some times	Rarely	Never
<b>Do you:</b>				
Find sunlight too bright and sunglasses a necessity?	O	S	R	N
Find fluorescent lighting too bright and uncomfortable to read <u>or</u> work under?	O	S	R	N
Squint when outside because the light bothers you?	O	S	R	N
Have difficulty adjusting from: bright lights to darkness	O	S	R	N
: darkness to bright lights?	O	S	R	N
Find computer screens / white boards seem bright?	O	S	R	N
Find headlights <u>or</u> streetlights have halos around them?	O	S	R	N
Find magazine <u>or</u> text book pages seem shiny or glossy, so you adjust the book in order to eliminate glare?	O	S	R	N
Suffer with headaches <u>or</u> migraines?	O	S	R	N
Feel fatigued at the end of the day?	O	S	R	N
Prefer to read in:	<input type="radio"/> dim light <input type="radio"/> bright light <input type="radio"/> either      (Please tick)			

<u>Depth Perception</u>	Often	Some times	Rarely	Never
<b>Do you:</b>				
Like to hold onto the railing when walking up <u>or</u> down stairs?	O	S	R	N
Bump into objects / furniture?	O	S	R	N
Veer into people when walking beside them?	O	S	R	N
Have difficulty stepping onto <u>or</u> off escalators?	O	S	R	N
Ever feel dizzy when walking?	O	S	R	N
See yourself as clumsy?	O	S	R	N
Experience motion sickness?	O	S	R	N
Have difficulty following the ball when watching ball sports on television?	O	S	R	N
<b>While driving do you:</b>				
Have difficulty judging the distance of oncoming traffic?	O	S	R	N
Leave lots of room between your car and the car ahead?	O	S	R	N
Have difficulty making lane changes <u>or</u> are extra cautious?	O	S	R	N
Feel nervous about passing cars on a two lane road?	O	S	R	N
Tailgate <u>or</u> do your passengers tense when you change lanes?	O	S	R	N
When parking do you hit the kerb <u>or</u> leave lots of room between the car and the kerb?	O	S	R	N

Please bring this questionnaire to your appointment.