COVD – QOL Checklist Questionnaire

Check the column which best represents the occurrence of each symptom.

Name: ____ Date: _____________

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
1. Headaches with near work					
2. Words run together reading					
3. Burning, itchy, watery eyes					
4. Skips/repeats lines reading					
5. Tilts head/closes one eye when reading					
6. Difficulty copying from chalkboard					
7. Avoids near work/reading					
8. Omits small words when reading					
9. Writes up/down hill					
10. Misaligns digits/columns of numbers					
11. Reading comprehension down					
12. Holds reading too close					
13. Trouble keeping attention on reading					
14. Difficulty completing assignments on time					
15. Always says 'I can't' before trying					
16. Clumsy, knocks things over					
17. Does not use time well					
18. Loses things/belongings					
19. Forgetful/poor memory					

PRE-TREATMENT TOTALS					
POST-TREATMENT TOTALS					

Other Comments: