New Sight
Vision Therapy Clinic

Name:_____ Date: _____ Age:_____

Brain Injury? Yes / No If yes, date of brain injury:_____

Please rate each behavior. **How often does each behavior occur?** (circle a number)	Never	Seldom	Occasionally	Frequently	Always
EYESIGHT CLARITY					
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel “pulling” around the eyes	0	1	2	3	4
DOUBLING					
Print moves in and out of focus when reading	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead--isn’t always straight ahead	0	1	2	3	4
Avoid crowds / can’t tolerate “visually-busy” places	0	1	2	3	4
READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can’t remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4
TOTALS					

≥28 = Likely Visual Impairment Your Score =

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