ACHIEVE
VISION CENTER

A Service of
ACHIEVE OCCUPATIONAL THERAPY SOLUTIONS, INC.

Parent's Name: _____

Child's Name: _____

Date: _____

19 Item COVD-QOL Checklist Questionnaire

Check the column which best represents the occurrence of each symptom

	Never	Once in a While	Sometimes	A Lot	Always
Headaches with near work					
Words run together reading					
Burn, Itch, Watery eyes					
Skips/Repeats lines reading					
Head tilt / Close one eye when reading					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns					
Reading comprehension down					
Holds reading too close					
Trouble keeping attention on reading					
Difficult completing assignments on time					
Always says "I can't' before trying					
Clumsy, knocks things over					

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Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

Total Score:

_____

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