INSIGHT
FAMILY EYE CARE

Insight Family Eye Care

Questionnaire for Ages 6-11

Patient's Name:_____ **Age:**_____
Grade:_____ **Date:**_____

Please put a number inside of the column that best fits how often these behaviors occur for your child.

Behavior:	Never (0)	Seldom (1)	Occasionally (2)	Frequently (3)
1. Homework/class work takes a long time to complete/is very difficult				
2. Bumps into things/clumsy				
3. Copying from board at school is difficult				
4. Eyes burn/easily irritated				
5. Has a difficult time/does not write in a straight line				
6. Holds books up close to face				
7. Has frequent headaches during or after reading/writing				
8. Has a hard time focusing during school/stays off task				
9. Tilts head/closes an eye when trying to read				
10. Misses words/letters when reading material				
11. Doesn't read at the grade level they should/doesn't like to read				
12. Has frequent daydreaming or dozing off episodes				
13. Doesn't believe he/she can complete certain tasks				
14. Has difficulty riding a bike?				

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