VISION BY DESIGN BRAIN INJURY SYMPTOM SURVEY

Year since brain injury _____ Age _____ Today's Date _____

- ☐ I have had a medical diagnosis of brain injury (If true) Cause of Injury _____
- ☐ I sustained a brain injury without medical diagnosis (If true) Cause of Injury _____
- ☐ I have NOT sustained a brain injury

How often does each occur?	Never	Seldom	Occasionally	Frequently	Always
Distance vision blurred and not clear -- even with lenses	0	1	2	3	4
Near vision blurred and not clear -- even with lenses	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
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
Double vision -- especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Sensitive to indoor lighting due to glare	0	1	2	3	4
Sensitive to outdoor light - need sunglasses	0	1	2	3	4
Fluorescent lighting is bothersome or annoying	0	1	2	3	4
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Frequently rubbing eyes	0	1	2	3	4
Clumsy / misjudges where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
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
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

Total Score ☐