



HELLERSTEIN & BRENNER
VISION CENTER, P.C.

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Your Name: _____ Your Age: _____ Today's Date: _____

- I have had a medical diagnosis of brain injury (check box if true).
- I suffered a brain injury without medical diagnosis (check box if true)
- I have NOT had a previous brain injury (check box if true)

My brain injury was: ____ years ago

Please check the most appropriate box, or circle the item number that best matches.

Please rate each behavior. How often does each behavior occur? (circle a number)	Never	Seldom	Occasionally	Frequently	Always
Clarity of vision changes or fluctuates during the day	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
Print moves in and out of focus when reading	0	1	2	3	4
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
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	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

Predictive score ≥ 28

Total Score for all 18 items: _____

Checklist courtesy of Pacific University College of Optometry