Date Completed: Parent/Guardian Initial:

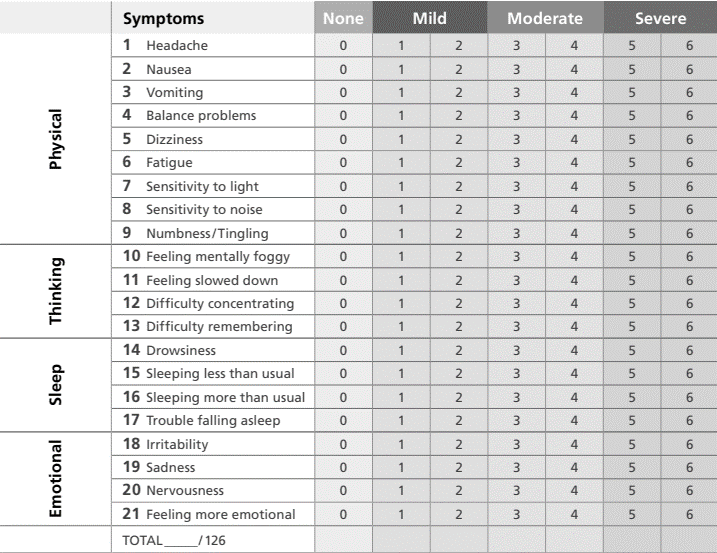
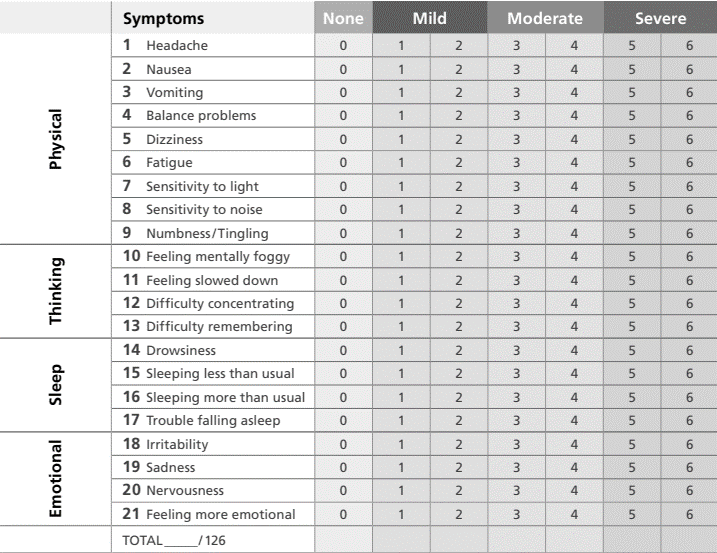
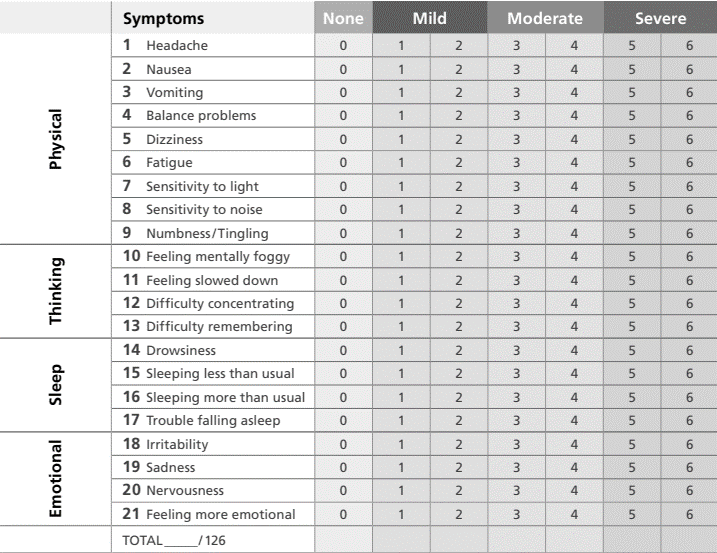
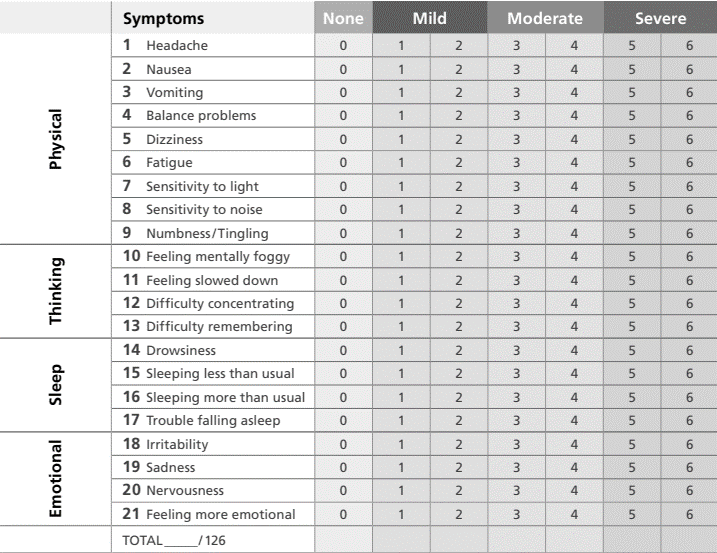
Do you have any visual problems? Yes No

Do these symptoms worsen with:

• Physical Activity: Yes No Not applicable

• Thinking/Cognitive Activity: Yes No Not applicable

Daily activity level \_\_\_\_\_ % of normal.



Date Completed: Parent/Guardian Initial:

Do you have any visual problems? Yes No

Do these symptoms worsen with:

• Physical Activity: Yes No Not applicable

• Thinking/Cognitive Activity: Yes No Not applicable

Daily activity level \_\_\_\_\_ % of normal.

Date Completed: Parent/Guardian Initial:

Do you have any visual problems? Yes No

Do these symptoms worsen with:

• Physical Activity: Yes No Not applicable

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Daily activity level \_\_\_\_\_ % of normal.

Date Completed: Parent/Guardian Initial:

Do you have any visual problems? Yes No

Do these symptoms worsen with:

• Physical Activity: Yes No Not applicable

• Thinking/Cognitive Activity: Yes No Not applicable

Daily activity level \_\_\_\_\_ % of normal.