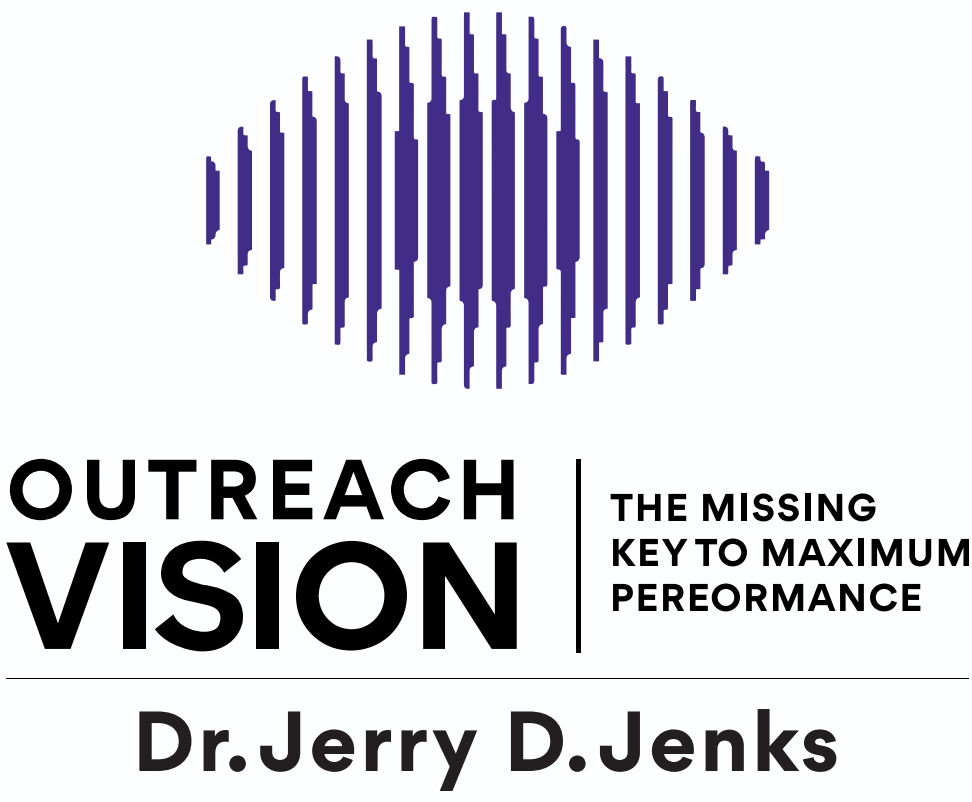


BVD SCREENING TEST

Binocular Vision Dysfunction Questionnaire (BVDQ™)



Name _____ Date _____

Phone Number _____ Email _____

FOR AGES 4-8

Directions: Children - answer these questions together with your Parent/Guardian. For every question, please answer YES or NO. If you wear glasses, answer the questions assuming that you are wearing them.

DOES YOUR CHILD:		YES	NO
A	have difficulty reading or learning OR skip letters or words or lines OR misread words or reverse numbers or words OR lose their place often while reading?		
B	have poor handwriting – poor letter sizing (too big or too small), poor spacing, writing lines with an upward or downward slant?		
C	avoid near activities OR do they act out after 5-10 minutes if they must perform near activities?		
D	sit very close to the TV / monitor / electronic devices OR hold toys very close to their face to see them?		
E	have difficulty identifying shapes, colors, letters, numbers and common images that are age appropriate?		
F	walk with difficulty (do they sway, trip or fall OR bump into objects or people) OR avoid climbing on furniture or outdoor playscapes?		
G	have trouble seeing the board, or seeing up close?		
H	have difficulty catching or kicking a ball?		
I	have headaches or stomach aches at school, pre-school or when away from home?		
J	have light sensitivity (closes/covers eyes in bright light) OR not like bright places?		
K	close or cover one eye when doing up close activities?		
L	have nervousness or anxiety OR get startled often OR is clingy in stores?		
M	squint or blink or make faces to “see”?		
TOTALS			

Parent/Guardian: Has your child ever been diagnosed with:

	YES	NO		YES	NO
Learning Disability (LD)?			Migraines or headache?		
Dyslexia?			Traumatic brain injury or concussion?		
Torticollis?			Does your child blink his/her eyes a lot/much more than most children?		
Lazy eye?			Are your child's verbal skills far ahead of his/her reading skills?		
ADD/ADHD?			Has your child ever had an eye operation?		

		None		Worst		None		Worst																
On an average day, how much are you bothered by symptoms listed here? Rate each symptom from 0 -10 0 = None of that symptom 10 = Worst	Dizziness	0	1	2	3	4	5	6	7	8	9	10	Neckache	0	1	2	3	4	5	6	7	8	9	10
	Nausea	0	1	2	3	4	5	6	7	8	9	10	Unsteady when walking	0	1	2	3	4	5	6	7	8	9	10
	Anxiety	0	1	2	3	4	5	6	7	8	9	10	Sensitivity to light	0	1	2	3	4	5	6	7	8	9	10
	Headache	0	1	2	3	4	5	6	7	8	9	10	Reading difficulty	0	1	2	3	4	5	6	7	8	9	10
													Sound sensitivity	0	1	2	3	4	5	6	7	8	9	10

This questionnaire is designed to screen for children who may be having symptoms due to a vision misalignment.

If your 4 or or more of the questions A through M were answered YES, schedule an appointment today.

Treatment is low cost and uses microprism lenses, and if indicated, noise cancelling devices. The average patient requires two appointments and two sets of lenses over 6-8 weeks, and can expect to experience an 80% reduction of symptoms.

Connect with a scheduler today:

SCAN TO CALL



CALL / TEXT

(816) 858-6080

OUTREACH VISION
700 Branch St, Suite 6, Platte City, MO 64079



OUTREACH VISION
THE MISSING KEY TO MAXIMUM PEREORMANCE
Dr. Jerry D. Jenks

This questionnaire is designed to screen for those who may have difficulty with vision alignment. The information obtained herein is considered a preliminary result only and does not diagnose or constitute confirmation of any vision problems. It is not a substitute for a NeuroVisual examination. Since vision changes can occur without visible indications, most eye care professionals and medical authorities recommend a vision exam annually.