

Pediatric Vertical Heterophoria Symptom Questionnaire (P-VHSQ-I&A)

(Initial and Annual) *for children 17 years old and younger*

Vision Specialists of Michigan

2550 S. Telegraph Road, Suite 100
www.VSofM.com

Bloomfield Hills, Michigan 48302

(248) 258-9000
 Fax (248) 499-6372

Name: _____ Email: _____ Date: _____

Best phone number: _____ Back-up phone number: _____

Directions: Children - answer these questions together with your Parents. For every question, check the answer that best describes your situation. If you wear glasses or contact lenses, answer the questions assuming that you are wearing them.

Never = Never
Occasionally = Less than 1 time / week
Frequently = At least 1 time / week
Always = Everyday

	✓ NEVER	✓ OCCASIONALLY	✓ FREQUENTLY	✓ ALWAYS
1. Do you have headaches or face pain?				
2. Do your eyes hurt and/or does it hurt to move your eyes?				
3. Do you have neck pain or a stiff neck or upper back pain?				
4. Do you have stomach aches or nausea?				
5. Do you get car sickness or motion sickness?				
6. Did you get sick in the car seat when you were a small child?				
7. Do you get sick to your stomach or nauseous on swings or circular rides?				
8. Does riding in the car give you headaches or stomach aches?				
9. Do you have trouble reading in the car?				
10. Do you feel clumsy or klutzy or uncoordinated?				
11. When you are walking, do you bump into people or furniture or door frames?				
12. Do you feel funny or dizzy when you bend over and stand back up quickly?				
13. Are you anxious or nervous?				
14. In grocery stores or malls, do you stay close (cling) to your Mom or Dad? (Do you feel uncomfortable in grocery stores or malls?)				
15. Do you tend to play alone or with just a few other kids? (Do you tend to play apart from the main group of kids?)				
16. Is reading hard for you or are you a slow reader?				
17. Do you have to read the same thing a couple of times to really understand it?				

