

Screening Visual Complaints questionnaire

Version: acquired brain injury

SVCq-abi

Version 1.0, 2024

DISCLAIMER: The following questionnaire is a first English translation of the original Dutch questionnaire. This English version has not been validated yet and therefore does not guarantee similar validity and reliability as the Dutch version.

The SVCq-abi has been developed for use in rehabilitation settings to screen for visual complaints in individuals with acquired brain injury.

Name/client ID:.....

Date of birth:.....

Test date:

This questionnaire starts on the next page and consists of 3 pages.

Instructions

This questionnaire concerns problems that you may experience with your eyesight. If you wear glasses or contact lenses, please assume that you are wearing these when you answer the questions. Each question has several answer options. Please choose the answer that is most appropriate to your situation as it has been over the past weeks. Please choose 1 answer for each of the following questions. If you don't know for sure, choose the most appropriate answer option.

| | Yes | No |
|--|--------------------------|--------------------------|
| Did you ever visit an ophthalmologist? | <input type="checkbox"/> | <input type="checkbox"/> |

If 'Yes': Which ophthalmologist did you visit?

.....
.....

For which ophthalmic condition did you visit an ophthalmologist?

.....
.....

| | No/ Rarely | Sometimes | Often/ Always |
|--|--------------------------|--------------------------|--------------------------|
| 1 Do you experience problems with your eyesight in daily life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If 'Sometimes' or 'Often/Always': please describe your problems or complaints regarding your eyesight

a

b

c

d

| | No/ rarely | Sometimes | Often/ Always |
|---|--------------------------|--------------------------|--------------------------|
| 2 Do you feel that your vision has become less clear? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Do you have trouble reading <u>due to your vision</u> ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Do you experience double vision or see double images? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Do you have trouble focusing or does it take longer before things are in focus? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Are you more easily blinded by bright light than before? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Do you experience color differently than before? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Do you have vision problems when you participate in traffic (e.g. walking, cycling, public transport or driving)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 Do you have trouble finding and looking for things because of your vision? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Do you have trouble seeing things with reduced contrast (e.g. letters that have not been printed on a white but on a grey background)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 Do you, more than before, have difficulty getting adjusted to light or dark environments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 Do you have the impression that you perceive objects or faces differently, e.g. distorted or with afterimages? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 Do you need more light than before? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 Do you have the impression that everything looks darker than before? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | No/ rarely | Sometimes | Often/ Always |
|---|--------------------------|--------------------------|--------------------------|
| 15 Do you have trouble moving from A to B because of vision (e.g. bumping, stumbling, climbing stairs, finding your way)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 Do you feel that you need more time to see things? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17 Are your eyes more painful than before? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 Are you bothered by dry eyes more than before? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 Do you see things that others do not see (e.g. flashes, stars, patterns, animals, objects, or animals)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 Do you have problems with depth perception or estimating distances? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21 Do you have the impression that you cannot see part(s) of the visual field? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22 Do you have difficulty grabbing objects accurately or do you sometimes miss (e.g., picking up a glass or grabbing a doorknob)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

23 To what extent do you experience limitations in daily life due to the above mentioned problems?

0 = no limitations

10 = very severe limitations

0 1 2 3 4 5 6 7 8 9 10

Please check whether you answered all questions.

One answer must be ticked for each question.

Thank you for completing the questionnaire.