CONVERGENCE INSUFFICIENCY SYMPTOM SURVEY

Name_____ Date ___/___/_____

Please answer the following questions about how your eyes feel when reading or doing close work.

SYMPTOMS *(Please fill this out with your child)*	NEVER	INFREQUENTLY	SOMETIMES	FAIRLY OFTEN	ALWAYS
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading or doing close work?					
Do you have headaches when reading or doing close work?					
Do you feel sleepy when reading or doing close work?					
Do you lose concentration when reading or doing close work?					
Do you have trouble remembering what you have read?					
Do you have double vision when reading or doing close work?					
Do you see the words move, jump, swim or appear to float on the page?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading or doing close work?					
Do your eyes ever feel sore when reading or doing close work?					
Do you feel a pulling feeling around your eyes when reading or doing close work?					
Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
Do you lose your place while reading or doing close work?					
Do you have to reread the same line of words when reading?					
TOTAL (Please add up each of the columns)					
MULTIPLY THE TOTAL BY THE FOLLOWING:	x0	x1	x2	x3	x4
SUBTOTAL					

GRAND TOTAL: (Sum of Subtotals)

To score the survey, simply add the check marks in each column and multiply the amount by the multiplier at the bottom of the survey. A score of 16 or more indicates the need of a developmental vision exam.

This symptom survey is derived from the National Institute of Health's Convergence Insufficiency Treatment Trial.