

CONVERGENCE INSUFFICIENCY SYMPTOM SURVEY

Date ___ / ___ / ___

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

| SYMPTOMS <i>(Please fill this out with your child)</i> | 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 <i>(Please add up each of the columns)</i> | | | | | |
| 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.