ACHIEVE
VISION CENTER

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Convergence Insufficiency Symptom Survey

Name _____ DATE _____

Clinician instructions: Read the following subject instructions and then each item exactly as written. If subject responds with "yes" - please qualify with frequency choices. Do not give examples,

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

		Never	(not very often)	Sometimes	Fairly often	Always
1 .	Do your eyes feel tired when reading or doing close work?					
2.	Do your eyes feel uncomfortable when reading or doing close work?					
3.	Do you have headaches when reading or doing close work?					
4.	Do you feel sleepy when reading or doing close work?					
5.	Do you lose concentration when reading or doing close work?					
6.	Do you have trouble remembering what you have read?					
7.	Do you have double vision when reading or doing close work?					
8.	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9.	Do you feel like you read slowly?					
10.	Do your eyes ever hurt when reading or doing close work?					

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11 .	Do your eyes ever feel sore when reading or doing close work?					
12.	Do you feel a "pulling" feeling around your e es when reading or doing close work?					
13.	Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14.	Do you lose your place while reading or doing close work?					
15.	Do you have to re-read the same line of words when reading?					

TOTAL SCORE

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