ORILLIA OPTOMETRY
EYE CARE & GALLERY
TEAMWORK VISION THERAPY

NAME: _____

DATE: _____

	Please check each box that corresponds to the frequency of each question.	Never	Not Very Often	Some-times	Fairly Often	Always
	CITT Symptom Survey					
1	How often do your eyes feel tired when reading or doing close work?	○	○	○	○	○
2	How often do your eyes feel uncomfortable when reading or doing close work?	○	○	○	○	○
3	How often do you have headaches when reading or doing close work?	○	○	○	○	○
4	How often do you feel sleepy when reading or doing close work?	○	○	○	○	○
5	How often do you lose concentration when reading or doing close work?	○	○	○	○	○
6	How often do you have trouble remembering what you have read?	○	○	○	○	○
7	How often do you have double vision when reading or doing close work?	○	○	○	○	○
8	How often do you see the words move, jump, swim or appear to float on the page when reading or doing close work?	○	○	○	○	○
9	How often do you feel like you read slowly?	○	○	○	○	○
10	How often do your eyes ever hurt when reading or doing close work?	○	○	○	○	○
11	How often do your eyes ever feel sore when reading or doing close work?	○	○	○	○	○
12	How often do you feel a “pulling” feeling around your eyes when reading or doing close work?	○	○	○	○	○
13	How often do you notice the words blurring or coming in and out of focus when reading or doing close work?	○	○	○	○	○
14	How often do you lose your place while reading or doing close work?	○	○	○	○	○
15	How often do you have to re-read the same line of words when reading?	○	○	○	○	○
	Office Use ONLY: Column Total					
		0	1	2	3	4
	Office Use ONLY: GRAND TOTAL					16