CALGARY VISION THERAPY BRENT W. NEUFELD, O.D.
Suite 130 – 4000 Glenmore Court SE, Calgary, AB 403-242-1800 Clinical Director

ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully and completely.
This form needs to be returned to our office at your scheduled appointment time.

Date: _____

GENERAL INFORMATION

Full Name: _____ Male □ Female □
Birth Date: _____ Age: ____
Home Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____
Contact email address: _____
Alberta Health Care#_____

Were you referred to our office? Yes □ No □
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____

What **specific areas of difficulty** does the **individual referring** feel you may be experiencing?
_____
_____
_____

What specific problems are **YOU** noticing/observing?
_____
_____
_____
_____

How long has this problem/difficulty been observed? _____

What are you hoping to determine through this evaluation? _____
_____
_____
_____

MEDICAL HISTORY
List illnesses, bad falls, high fevers, chronic ear infections, hospitalizations etc:
Age Event Severe / Mild Complications
_____
_____
_____
_____
Are you generally healthy? Yes □ No □ If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes □ No □
If yes, please list: _____
Family Doctor (circle): _____ Date of most recent evaluation: _____
For what problem/condition? _____
Results and recommendations: _____
_____
Current state of health (explain): _____
Medications currently using including vitamins and supplements: _____
_____

_____

For what condition(s)? _____

_____

Are you allergic to any foods or medications? Yes ☐ No ☐

If yes, please list: _____

Is there any **family history** of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	Strabismus / crossed eye	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Blindness	☐	☐	_____	Thyroid Condition	☐	☐	_____
Glaucoma	☐	☐	_____	Cataracts	☐	☐	_____
High blood pressure	☐	☐	_____	Brain Tumor	☐	☐	_____
ADD / ADHD	☐	☐	_____	Learning Disability	☐	☐	_____
Other	☐	☐	_____				

If other, please explain: _____

_____

If ADD/ADHD or a Learning Disability was diagnosed, who diagnosed it, how was it diagnosed and when?

_____

_____

VISUAL HISTORY

Have you had a previous vision examination? Yes ☐ No ☐

If yes, Doctor's Name: _____Date of last visit: _____

Reason for examination: _____

Results and recommendations: _____

_____

Were glasses, contact lenses or other optical devices recommended? Yes ☐ No ☐

If yes, what? _____

Do you use them? Yes ☐ No ☐

How long have you had them? _____

If used, when? _____

If not used, why not? _____

If you wear contact lenses, how long have you worn them? _____

What type of lenses do you have (i.e. hard, soft, gas-permeable)? _____

If soft lenses, what brand and strength of powers do you wear? _____

If disposable soft lenses, how often do you throw out your contact lenses and put in your new pair? _____

Do you sleep in your contact lenses? Yes ☐ No ☐

If yes, how many days do you sleep in your contact lenses? _____

What contact lens solutions do you use? _____

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRESENT SITUATION

Do you experience any of the following?	**Yes**	**No**	**If yes, when?**
Blurred vision at distance	☐	☐	_____
Blurred vision at near	☐	☐	_____
Red or itchy eyes	☐	☐	_____
Burning eyes	☐	☐	_____
Frequent Styes	☐	☐	_____
Watery eyes	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes feel tired	☐	☐	_____
Headaches	☐	☐	_____

	Yes	No	If yes, when?
Nausea associate with visual tasks	☐	☐	_____
Double vision at distance	☐	☐	_____
Double vision at near	☐	☐	_____
Tilt head during desk work	☐	☐	_____
Squinting, covering or closing one eye	☐	☐	_____
Postural changes when doing desk work	☐	☐	_____
Need for very bright light when reading	☐	☐	_____
Need for very dim light when reading	☐	☐	_____
Loss of interest or short attention span for close work	☐	☐	_____
Difficulty sustaining reading/writing	☐	☐	_____
General or visual fatigue at the end of the day	☐	☐	_____
Loss of place when reading	☐	☐	_____
Skip lines when reading	☐	☐	_____
Repetition of letter or words when reading	☐	☐	_____
Omission of words when reading / copying	☐	☐	_____
Use of finger to keep place	☐	☐	_____
Head moves when reading	☐	☐	_____
Confusion of what is being seen or read	☐	☐	_____
Falling asleep when reading	☐	☐	_____
Silent vocalization/moving lips when reading	☐	☐	_____
Motion / car sickness	☐	☐	_____
Difficulty with reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Letters or words appear to move or float around when reading	☐	☐	_____
Difficulty aligning columns of numbers	☐	☐	_____
Can respond better orally than in writing	☐	☐	_____
Write or print poorly	☐	☐	_____
Poor time management	☐	☐	_____
Inconsistent performance in work or sports	☐	☐	_____
Poor general coordination / clumsiness	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulties with short-term memory	☐	☐	_____
Difficulties with long-term memory	☐	☐	_____

Comments on any items above or additional items: _____
_____
_____
_____

Place an X in the column that best describes yourself. How often do you experience the following symptoms?

	NEVER	ONCE IN A LONG WHILE	SOMETIMES	A LOT	ALWAYS
Blurred vision at near					
Double vision					
Headaches associated with near work					
Words run together when reading					
Burning, stinging, watery eyes					
Falling asleep when reading					
Vision worse at the end of the day					
Skipping or repeating lines when reading					
Dizziness or nausea associated with near work					
Head tilt or closing one eye when reading					
Difficulty copying from the smartboard/screens					
Avoidance of reading and near work					
Omitting small words when reading					
Writing uphill or downhill					
Mis-aligning digits in columns of numbers					
Reading comprehension declining over time					
Inconsistent/poor sports performance					
Holding reading material too close					
Short attention span					
Poor eye-hand coordination (poor handwriting)					
Saying "I can't" before trying					
Avoiding sports and games					
Tendency to knock things over on desk or table					

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes □ No □

If so, indicate the types of computer work you perform:

- □ Word processing
- □ Programming
- □ Data entry
- □ Internet
- □ Games / leisure activities
- □ Research
- □ Other (explain): _____

How many hours do you spend in front of a computer screen each day? _____

How many hours do you spend in front of a digital device each day (including smartphone/tablet)? _____

How do your eyes feel after working at the computer? _____

Where is the top of the screen located?

- □ Above your straight-ahead eye level
- □ At eye level
- □ Below eye level

What is the distance from: Your eyes to the screen? _____

Your eyes to the keyboard? _____

Your eyes to your source documents? _____

Where is the computer screen located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left

Where are your source documents located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left
- □ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- □ Glare from windows or other light sources
- □ Reflections on your computer screen
- □ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

- □ Glasses
- □ Contact lenses
- □ Other (explain): _____

Please describe any problems you have with your vision, current glasses or contact lenses for computer work:

_____

_____

_____

_____

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____

How many hours daily do you spend at a desk? _____

How many hours daily do you spend reading or studying? _____

How many hours do you spend working at near distances? _____

Do you feel you are achieving to your potential in work or school? Yes □ No □

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes □ No □

If no, please explain: _____

Does your work or course of study demand comprehension from the written word? Yes □ No □
Describe briefly your daily activities at work or in school: _____
_____

HOBBIES / SPORTS
Describe the types of activities that comprise the majority of your leisure time: _____
_____
_____
_____
Do you watch TV? Yes □ No □
If yes, how many hours per day? _____
Are you seriously involved with athletics? Yes □ No □
Do you feel you are achieving up to your potential in sports/athletics? Yes □ No □
Of all the sports you have played:
List the ones in which you excel: _____
List the ones in which you do poorly/avoid: _____

IS THERE ANY OTHER INFORMATION THAT YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR EVALUATION / TREATMENT?

_____
_____
_____

RELEASE OF VISUAL INFORMATION PROCESSING EVALUATION REPORT

A comprehensive report will be prepared at the completion of visual information processing testing. The report will detail the testing performed, the specific visual abilities evaluated, and how the patient performed. It will discuss the implications of the visual dysfunction on performance in academic, sports and daily activities and will make recommendations for remediation of the visual problems.

We highly recommend that you send reports to teachers, school counselors, school principles and other professionals (including your eye care practitioner – even if he/she did not directly refer you to our office) currently providing care for the patient. Please list below the specific individuals you would like Dr. Neufeld to send a copy of the report to.

I hereby give my permission to Calgary Vision Therapy to release reports to the Names and Addresses provided below.

Patient or Guardian's Signature _____ Date: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

RELEASE OF INFORMATION

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign the below to authorize the release of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers when it is necessary for the treatment of my visual condition. If I was referred by an optometrist, I agree to allow Dr. Neufeld send the referring optometrist a summary of the results of the testing along with recommendations given. This authorization shall be valid for the duration of treatment.

_____ _____

Signature or Authorized Representative Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status. We ask that you find alternate arrangements for looking after any other children (to prevent unnecessary distractions). Please ensure that you have a good night's sleep the night before the appointment and have had something to eat prior to the appointment so hunger will not be a distraction. We are looking forward to meeting you.

For more information on visual training, visit www.calgaryvt.com, www.visiontherapy.com

Please Initial here _____ to confirm you have read these forms and filled them out to the best of your knowledge.

Sincerely,

Brent W. Neufeld, O.D.
Clinical Director
www.calgaryvt.com
https://www.facebook.com/pages/Calgary-Vision-Therapy/335004866603062

All appointments with Dr Neufeld (binocular coordination evaluation and parent consultation) is at the Eye Live office: 346, 100 Auburn Meadows Drive SE Calgary, AB T3M 2G5 403-719-5483

The Visual Information Processing evaluation is at the Calgary Vision Therapy office with a vision therapist: 130, 4000 Glenmore Court SE, Calgary, AB T2C 5R8 403-242-1800