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

Binocular Vision/Strabismus/Amblyopia Evaluation Pre-Exam Questionnaire

Child

Please fill out this questionnaire carefully. This form must be returned to our office at your scheduled appointment.

Date: _____

GENERAL INFORMATION

Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____
Child's Full Name: _____
Birth Date: _____ Age: ____ years ___ months
Alberta Health Care #_____
Name and address of school: _____
_____
_____
Grade: _____ Teacher: _____ Principal: _____
Is your child especially afraid of doctors? _____
Child's dominant hand (circle): right or left? Has guidance been given in use of hand? Y / N

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City: _____ Postal Code _____
Home Phone: _____ Business Phone: _____
Contact email: _____
Father/Caretaker_____ Occupation: _____
Mother/Caretaker _____ Occupation: _____

What **specific areas of difficulty** does the **individual referring** your childfeel that he/she may be experiencing?
_____
_____
_____

What specific problems are **YOU (as the parent/guardian)** noticing/observing?
_____
_____
_____

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

If vision therapy would be appropriate for the child, what GOALS or end results would you be wanting to see or expecting?
_____
_____
_____

MEDICAL HISTORY

Pediatrician's Name: _____
Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Family Doctor's Name: _____
Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Child's current state of health: _____
Medications currently using, including vitamins and supplements: _____
_____
_____
For what condition(s)? _____
_____

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	Glaucoma	☐	☐	_____
High blood pressure	☐	☐	_____	Learning Disability	☐	☐	_____
Chromosomal Imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
				Blindness	☐	☐	_____
ADD/ADHD	☐	☐	_____	Epilepsy or Seizures	☐	☐	_____
Thyroid condition	☐	☐	_____	Brain Tumor	☐	☐	_____
Autism	☐	☐	_____	Other	☐	☐	_____

If other, please explain: _____
_____
If ADD/ADHD was diagnosed, who diagnosed it? _____

Any history in your family of an eye turn resulting from disease or other condition? Yes ☐ No ☐
Other health problems? Yes ☐ No ☐
If yes, please explain: _____
Was there any related trauma, disease or condition that preceded or accompanied the onset of the eye turn?
Yes ☐ No ☐ If yes, please explain: _____
_____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list _____

List illnesses, bad falls, high fevers, chronic ear infections, hospitalizations etc:

Age	Event	Severe / Mild	Complications

_____
_____
_____

Has a *neurological evaluation* been performed? Yes ☐ No ☐ When? _____
By whom? _____ Results and recommendations: _____
_____

Has an psychological evaluation been performed? Yes ☐ No ☐ When? _____
By whom? _____ Results and recommendations: _____
_____

Has an *occupational therapy* evaluation been performed? Yes ☐ No ☐ When? _____
By whom? _____ Results and recommendations: _____
_____

PLEASE INCLUDE COPIES OF REPORTS

NUTRITIONAL INFORMATION
Current Diet: Excellent □ Good □ Fair □ Poor □
Does your child: Like sweets □ or crave sweets □
If yes, what types? _____
Are there any food allergies/sensitivities? Yes □ No □
If so, please explain: _____
Is your child active? Yes □ No □ Moderately? Yes □ No □ Extremely? Yes □ No □

DEVELOPMENTAL HISTORY
Premature birth? Yes □ No □
Did the mother experience any problems during pregnancy? Yes □ No □
Normal birth? Yes □ No □ Birth weight: _____
Were forceps used? Yes □ No □
Any complications before, during, or immediately following delivery? Yes □ No □
Did your child crawl (stomach on floor)? Yes □ No □ At what age? _____
Did your child creep (on all fours)? Yes □ No □ At what age? _____
At what age did your child sit up (without support)? _____
At what age did your child walk (without support)? _____
Speech: First words: _____ At what age? _____
Was early speech clear to others? Yes □ No □
Is speech clear now? Yes □ No □
At what age did your child speak in a simple sentence (string two words together)? _____
Was your child alert as an infant? Yes □ No □
Was there ever any reason for concern over your child's general growth or development?
Yes □ No □ If yes, why? _____

VISUAL HISTORY
Has your child's vision been previously evaluated? Yes □ No □
If so, Doctor's Name: _____ Optometrist / Ophthalmologist
Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses or other optical devices recommended? Yes □ No □
If yes, what? _____
Are they used? Yes □ No □ If yes, when? _____
If not used, why not? _____

At what age did you first notice or suspect that was an eye turning? _____
Did the eye begin turning: Suddenly □ OR Gradually □?
Does the eye turn: IN □ OUT □ UP □ or DOWN □ ? (Check all that apply)
Is the eye turn getting worse or better, or is there no change? _____
Is it always the same eye that turns? Yes □ No □ If yes, which eye? Right □ Left □
Is the eye turn always present? Yes □ No □
If no, under what conditions is it present? _____
Does the eye always turn the same amount? Yes □ No □
If no, explain: _____
Do you notice if the eye turns more when you look:
Up close? Yes □ No □
In the distance? Yes □ No □
To your left? Yes □ No □
To your right? Yes □ No □
Up? Yes □ No □
Down? Yes □ No □
Does one pupil ever appear to be larger than the other? Yes □ No □
Do you ever notice one or both eyes shaking rapidly? Yes □ No □

Does your child experience any of the following?	**Yes**	**No**	**If yes, when?**
Headaches	☐	☐	_____
Blurred vision	☐	☐	_____
Double vision	☐	☐	_____
Eyes “tired” or “hurt”	☐	☐	_____
Redness of the eyes	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____

List any other complaints your child makes concerning his/her vision: _____
_____

Do you feel your child’s vision hinders his/her daily activities in any way? Yes ☐ No ☐
If yes, how? _____

Have you or anyone else noticed the following:

	Yes	**No**	**If yes, when?**
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Frequent styes	☐	☐	_____
Closes or covers an eye	☐	☐	_____
Bothered by light	☐	☐	_____
Difficulty seeing distant objects	☐	☐	_____
Head close to paper when writing	☐	☐	_____
Avoids/dislikes reading or other near tasks	☐	☐	_____
Tilts head when reading or writing	☐	☐	_____
Moves head when reading	☐	☐	_____
Confusion of letters or words	☐	☐	_____
Reverses letters or words	☐	☐	_____
Confuses right or left	☐	☐	_____
Skipping or omitting words	☐	☐	_____
Loses place when reading	☐	☐	_____
Uses finger as marker	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Write or print poorly	☐	☐	_____
Difficulty copying from the chalkboard	☐	☐	_____
Tires easily	☐	☐	_____
Difficulty with short term memory	☐	☐	_____
Difficulty with long term memory	☐	☐	_____
Short attention span / lost of interest	☐	☐	_____
Poor / awkward general motor coordination	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulty judging distances	☐	☐	_____
Difficulty driving	☐	☐	_____
Dislike / avoid sports	☐	☐	_____
Difficulty hitting/catching a ball	☐	☐	_____

Place an X in the column that best describes your child. How often does your child 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					

Are there any reading / learning concerns? Y / N

If yes, please elaborate: _____

_____

_____

PREVIOUS TREATMENTS

Has your child had a previous visual evaluation? 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:
GLASSES: bifocal □ OR single vision □;
Contact lenses □
Other □ Explain: _____

Are they (glasses / contact lenses) used? Yes □ No □
If yes, when are they worn? _____
If no, why not? _____
Does the eye turn less when the prescription is worn? Yes □ No □ Unsure □
Have you been told that you have amblyopia (lazy eye)? Yes □ No □
Has there been any treatment using an eye patch?Yes □ No □
If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: _____
_____

PREVIOUS SURGICAL TREATMENT

Has there been any surgical treatment? Yes □ No □
If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results: _____
_____
_____
Was the surgeon satisfied with the results? Yes □ No □ Explain:
_____
_____
Were you satisfied with the results of the surgery? Yes □ No □ Explain: _____
_____
Have surgical results been maintained? Yes □ No □ Explain: _____
_____
Are you here for a second opinion regarding surgery or other treatment? Yes □ No □

PREVIOUS VISION THERAPY TREATMENT

Has there been any visual therapy? Yes □ No □
If yes, Doctor's name: _____
Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results:
_____
_____
_____

FAMILY AND HOME

Please indicate which adult(s) he/she lives with? Mother □ Father □ Stepmother □ Stepfather □
Foster parents □ Adoptive parents □ Grandmother □ Grandfather □ Aunt □ Uncle □
Other Caretaker (please specify): _____
Does your child spend time with any other person, not in the home? Yes □ No □
Please explain: _____
Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? Yes □ No □ If yes, at what age? _____
Does your child seem to have adjusted? Yes □ No □
Was counseling/therapy undertaken? Yes □ No □ If yes, is it on-going? Yes □ No □
Is family life stable at this time? Yes □ No □ If no, please explain: _____

GENERAL BEHAVIOR

Are there any behavior problems at school? Yes □ No □
If yes, what? _____
Are there any behavior problems at home? Yes □No □
If yes, what? _____
What causes these problems? _____
Child's reaction to fatigue? Sag □ irritable □ other □ _____
Child's reaction to tension? Avoidance □ irritable □ other □ _____
Does your child say and/or do things impulsively? Yes □ No □
Is your child in constant motion? Yes □ No □
Can your child sit still for long periods? Yes □ No □

Are there any learning difficulties or learning concerns for this child? _____
_____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON: _____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

LIST OF EXTRA-CURRICULAR ACTIVITIES WHICH COMPETE WITH YOUR CHILD'S TIME AND ABILITY TO DO VISION THERAPY HOMEWORK (PLEASE LIST THE # OF DAYS PER WEEK AND TIME COMMITMENT TO EACH ACTIVITY):

_____
_____
_____
_____
_____
_____

RELEASE OF INFORMATION

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

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize Dr. Neufeld and Calgary Vision Therapy to exchange information with my child's school and other professionals involved with my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____
Signature Date

_____
Relationship to patient

I hereby give my permission to Calgary Vision Therapy, Dr. Brent W. Neufeld, O.D. and any of his trained assistants/visual therapists) to test / treat _____. I am aware that there is a fee for this testing due at the time of the evaluation.

_____ _____
Parent's or Guardian's Signature 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 of your child and to better meet your child's specific visual needs.

Results will be provided verbally after the evaluation. No written report is included in the evaluation fee. Should a written report be requested, a fee for the time to compose the report will be charged based on the Alberta Association of Optometrists fee guide for detailed letter/report (per hour). Any such requested written reports may take 4-6 weeks.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status. We ask that you find alternate arrangements for looking after any other children as only the parent/guardian and the child will be permitted into the evaluation rooms (to prevent unnecessary distractions). Please ensure that your child has a good night's sleep the night before the appointment and has had something to eat prior to the appointment so hunger will not be a distraction.

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.

Thank you,

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 / strabismus / amblyopia evaluation) is at the Eye Live office: 346, 100 Auburn Meadows Drive SE Calgary, AB T3M 2G5 403-719-5483

Any recommended Vision Therapy services will be at the Calgary Vision Therapy office: 130, 4000 Glenmore Court SE, Calgary, AB T2C 5R8 403-242-1800