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

VISUAL INFORMATION PROCESSING and Strabismus/Amblyopia PRE-EXAM QUESTIONNAIRE

Please fill out this questionnaire carefully and completely.
This form must be returned to our office at your first scheduled appointment.
Please include copies of previous special testing (i.e. psychologist/speech/occupational therapist reports).

Appointment: Day _____ Date: _____ Time: _____
Patient's Name: _____

GENERAL INFORMATION
Date: _____
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____
Address: _____

Child's Full Name: _____ Male ☐ Female ☐
Birthdate: _____ 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

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

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

How long has this problem/difficulty been observed? _____

Specific areas of difficulty in school: _____
_____
_____
_____

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

RESPONSIBLE PERSON INFORMATION
Home Address: _____ City: _____ Postal Code _____
Home Phone: _____ Business Phone: _____
Father/Caretaker's Name: _____ Occupation: _____
Mother/Caretaker's Name: _____ Occupation: _____
Email address: _____

MEDICAL HISTORY

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

Age Event Severe / Mild Complications

_____
_____
_____
_____

Is your child 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: _____

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)? _____
_____
Any reactions to immunization(s)? Yes □ No □
If yes, please explain: _____

PRIOR ADDITIONAL TESTING: ** PLEASE INCLUDE COPIES OF THOSE REPORTS **

Has any of the following additional testing been performed?
Psychological evaluation? Yes □ No □ By whom? _____ When? _____
Results and recommendations: _____
_____
Occupational therapy? Yes □ No □ By whom? _____ When? _____
Results and recommendations: _____
_____
Neurological evaluation? Yes □ No □ By whom? _____ When? _____
Results and recommendations: _____
_____
Speech/language therapy? Yes □ No □ By whom? _____ When? _____
Results and recommendations: _____
_____
Other additional testing? Yes □ No □ By whom? _____ When? _____
Results and recommendations: _____
_____
_____

FAMILY HISTORY

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

	Patient	Family	Who		Patient	Family	Who
ADD / ADHD	□	□	_____	Learning Disability	□	□	_____
"Cross" eye	□	□	_____	Amblyopia (lazy eye)	□	□	_____
Chromosomal Imbalance	□	□	_____	High Blood Pressure	□	□	_____
Glaucoma	□	□	_____	Epilepsy or Seizures	□	□	_____
Autism	□	□	_____	Other	□	□	_____

If other, please explain:
_____
If ADD/ADHD or a Learning Disability or dyslexia was diagnosed, who diagnosed it, how was it diagnosed and when?
_____
_____

NUTRITIONAL INFORMATION

Current Diet: Excellent □ Good □ Fair □ Poor □
Does your child: Like sweets □ or crave sweets □
If yes, what types? _____
Is your child active? Yes □ No □ :
Sluggish Yes □ No □; Moderately? Yes □ No □; Extremely? Yes □ No □
Are there periods of
Very high energy? Yes □ No □
Very low energy? Yes □ No □
Explain: _____

DEVELOPMENTAL HISTORY

Premature birth? Yes □ No □
Did the mother experience any health problems during the pregnancy? Yes □ No □
If yes, please explain: _____
Normal birth? Yes □ No □ Birth weight: _____
Any complications before, during or immediately following delivery? Yes □ No □
If yes, explain: _____
Was there ever any reason for concern over your child's general growth or development? Yes □ No □
If yes, why? _____
_____
Did your child crawl (stomach on floor)? Yes □ No □ At what age? _____
Did your child creep (on all fours)? Yes □ No □ At what age? _____
If not, describe: _____
_____+++++_____
At what age did your child walk? _____
Was child active? Yes □ No □
Speech: First words: _____ At what age: _____
Was early speech clear to others? Yes □ No □
Is speech clear now? Yes □ No □

VISUAL HISTORY

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: _____
_____

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 □

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? 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:
_____
_____
_____

PRESENT SITUATION
Is there any evidence from the school, psychologist, or other tests that indicates some visual malfunction may be present? Yes □ No □
If yes, what? _____
_____

Does your child report any of the following?	**Yes**	**No**	**If yes, when?**
Headaches	☐	☐	_____
Blurred vision / focus goes in and out	☐	☐	_____
Double vision	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes tired	☐	☐	_____
Words move around on the page	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____
Dizziness	☐	☐	_____

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

_____

Have you or anyone else ever noticed the following:

	Yes	**No**	**If yes, when?**
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Reverses letters/words	☐	☐	_____
Bothered by light	☐	☐	_____
Frequent blinking	☐	☐	_____
Closing or covering one eye	☐	☐	_____
Difficulty seeing distant objects	☐	☐	_____
Head close to paper when reading/writing	☐	☐	_____
Avoids reading	☐	☐	_____
Prefers being read to	☐	☐	_____
Tilts head when reading	☐	☐	_____
Tilts head when writing	☐	☐	_____
Moves head when reading	☐	☐	_____
Confuses letter or words	☐	☐	_____
Skips, rereads or omits words	☐	☐	_____
Loses place while reading	☐	☐	_____
Vocalizes when reading silently	☐	☐	_____
Reads slowly	☐	☐	_____
Uses finger as a marker	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Writes or prints poorly	☐	☐	_____
Writes neatly but slowly	☐	☐	_____
Does not support paper when writing	☐	☐	_____
Awkward or immature pencil grip	☐	☐	_____
Confuses left and right	☐	☐	_____
Tires easily	☐	☐	_____
Difficulty copying from chalkboard	☐	☐	_____
Difficulty recognizing same word on different page	☐	☐	_____
Poor word attack skills	☐	☐	_____
Difficulty with memory	☐	☐	_____
Remembers better what hears than sees	☐	☐	_____
Responds better orally than by writing	☐	☐	_____
Seems to know material, but does poorly on tests	☐	☐	_____
Dislikes / avoids near tasks	☐	☐	_____
Short attention span / loses interest	☐	☐	_____
Poor large motor coordination	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulty with scissors / small hand tools	☐	☐	_____
Dislikes / avoids sports	☐	☐	_____
Difficulty catching / hitting 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					

TELEVISION VIEWING / LEISURE TIME ACTIVITIES

How much does your child watch TV? _____ How often? _____ Viewing distance _____
Does your child spend time using computer/video games? Yes □ No □
If yes, how much? _____ How often? _____ Viewing distance _____
What other activities occupy your child's leisure time? _____
Are there any activities your child would like to participate in, but doesn't? _____
_____

SCHOOL

Age at time of entrance to: Kindergarten _____ First Grade _____
Does your child like school? Yes □ No □
Specifically describe any school difficulties: _____
_____
Favorite subject: _____ Least liked subject: _____
Easiest subject: _____ Most difficult subject: _____
Has your child changed schools often? Yes □ No □ If yes, when? _____
Has a grade been repeated? Yes □ No □
If yes, which grade and why? _____
Does your child seem to be under tension or extreme pressure when doing school work? Yes □ No □
Has your child had any special tutoring, therapy and/or remedial assistance? Yes □ No □
If yes, when? _____
Where and from whom? _____
How long? _____
Results? _____
Does your child like to read? Yes □ No □
Voluntarily? Yes □ No □
Does your child read for pleasure? Yes □ No □
What does he/she read? _____
What is your child's attitude towards reading, school, his/her teachers, other youngsters? _____
_____
Overall schoolwork is: above average □ average □ below average □
WHICH SUBJECTS ARE:
Above average: _____
Average: _____
Below average: _____
Does your child need to spend a lot of time/effort to maintain this level of performance? Yes □ No □
How much time on average does your child spend each day on homework assignments? _____
To what extent do you assist your child with homework? _____
Do you feel your child is achieving up to potential? Yes □No □
Does the teacher feel your child is achieving up to potential? Yes □ No □

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 □

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: _____
How does your child get along with:
Parents/other caretakers: _____
Siblings? _____
Classmates in school? _____
Playmates at home? _____
Did father or anyone in father's family have a learning problem? Yes □ No □
If yes, who? _____
Did mother or anyone in mother's family have a learning problem? Yes □ No □
If yes, who? _____
Do any, or did any, of the other children in the family have learning problems? Yes □ No □
If yes, who? _____
To what extent? _____
_____
_____

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

_____
_____
_____
_____
_____

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

Patient: _____

Parent Conference Date: _____

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 principal 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 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 _____. Parts of the testing may be video taped for the purposes of behavioral observation review by either the therapist or doctor and/or to be used as demonstrative purposes for the parents. I am aware that there is a fee for this specialized 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.

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, visitwww.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 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