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 yourscheduled 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)? ____
____

FAMILY HISTORY

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:

<u>Age</u> <u>Event</u> <u>Severe</u> / <u>Mild</u> <u>Complications</u>
____
____
____

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 □

SYMPTOMS

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 eyepatched, 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.calgaryvisiontherapy.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