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

VISUAL INFORMATION PROCESSING PRE-EXAM QUESTIONNAIRE

Please fill out this questionnaire carefully and completely and bring it to 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: ____

____
____

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's vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: __________________________ 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? ____
Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_______________________	______	____
_______________________	______	____
_______________________	______	____

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 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 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, 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 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