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

TBI / VISUAL INFORMATION PROCESSING PRE-EXAM QUESTIONNAIRE - CHILD

Please fill out this questionnaire <u>carefully</u> and completely.
This form must be returned to our office at your first scheduled appointment.

Appointment: Day ________________ Date: _____________________ Time: ___________

Patient's Name: ____
Address: ____
____
____
Home Phone Number: ____________________ Alternate Contact #: __________
Contact email address ________________________________

Birthdate: _____________________________________ Age: ____ years ____ months

Alberta Health Care #___________________________________

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

MEDICAL HISTORY
Date of injury/accident: ____
Type of injury/accident: Motor vehicle ☐ Fall ☐ Blow to head ☐ Industrial Accident ☐
Medication-related ☐ Drug abuse ☐ Poison or toxic substance ☐ Carbon dioxide ☐
Drowning ☐ Cord around neck ☐ Stroke ☐ Aneurysm ☐ Hemorrhage ☐
Other: ____
____

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):
Forehead ☐ Right side ☐ Left side ☐ Back of head ☐ Top of head ☐ Face ☐

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _______________

Did you lose consciousness? Yes ☐ No ☐ If yes, for how long? ___________________
Were you in a coma? Yes ☐ No ☐ If yes, how long? ______________________________

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)
Double vision ☐ Headache ☐ Blurred vision ☐ Pain in or around eyes ☐ Dizziness ☐
Vomiting ☐ Flashes of light ☐ Disorientation ☐ Loss of balance ☐
Neck pain/whiplash ☐ Loss of memory ☐ Restricted field of view ☐
Restricted motion ☐
Other: ____

INITIAL TREATMENT
When did you first see a doctor regarding your accident/injury? ______________________
Name of Doctor: ___________________________ Specialty: _____________________
Where were you seen? _________________Were you hospitalized? Yes ☐ No ☐ How long? ______________________________
What were you and your family told? ____
____
____
____

What did the initial treatments consist of? ______________________________________

What prognosis/recommendations were you given? ________________________________

Were you given medications? Yes ☐ No ☐ Medication: ___________________________

For what condition(s)? ____

List any medications, including vitamins and supplements used at the current time: _________
____

SUBSEQUENT/OTHER PROFESSIONALCARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and describe):

Physicians Name: ____ Date: _________
Results and recommendations: ____

Neurologist Name: ____ Date: _________
Results and recommendations: ____

Neuropsychologist Name: _____________________________________ Date: _________
Results and recommendations: ____

Physical Therapist Name: _____________________________________ Date: _________
Results and recommendations: ____

Speech / Language Therapist Name: ______________________________ Date: ________
Results and recommendations: ____

Psychologist / Psychiatrist Name: ______________________________ Date: ________
Results and recommendations: ____

Osteopathic Physicians Name: ______________________________ Date: ________
Results and recommendations: ____

Other / Name: ____ Date: ________
Results and recommendations: ____

Do you have a history of allergies? Yes ☐ No ☐
If yes, please explain: ____
Has a neurological evaluation been performed? Yes ☐ No ☐
If yes, by whom? ______________________________________ Date: ________
Results: ____
Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom? ______________________________________ Date: ________
Results: ____
Has a speech and language evaluation been performed? Yes ☐ No ☐
If yes, by whom? ______________________________________ Date: ________
Results: ____

MEDICAL HISTORY
Is there any history of the following? (please check if there is a history)

	Patient	**Family**	**Who**
High blood pressure	☐	☐	
_______________			
Diabetes	☐	☐	______________________
Thyroid condition	☐	☐	______________________
Multiple Sclerosis	☐	☐	______________________
Brain Tumor	☐	☐	______________________
Stroke	☐	☐	______________________
Traumatic brain injury	☐	☐	______________________
Glaucoma	☐	☐	______________________
Cataracts	☐	☐	______________________
Blindness	☐	☐	______________________
Strabismus	☐	☐	______________________
Amblyopia	☐	☐	______________________

VISUAL HISTORY

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

If yes, doctor's name: ____________________

Date of last evaluation: ____________________

Reason for examination: ____________________

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

If yes, what? ____________________

Are they used? Yes ☐ No ☐ If yes, when? ____________________

If no, why not? ____________________

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes ☐ No ☐

If yes, what? ____________________

Did you undergo these treatments? Yes ☐ No ☐ Explain: ____________________

Results and recommendations: ____________________

**** At least 1 week prior to your scheduled evaluation, contact your last eye care practitioner and have them fax (403-242-3833) or email calgaryvisiontherapy@gmail.com) copies of your last comprehensive eye examination at their office for reference. ****

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Prior to Injury?
Eyes ache	☐	☐	☐
Eyes pull or tug	☐	☐	☐
Difficulty moving or turning eyes	☐	☐	☐
Pain with movement of eyes	☐	☐	☐
Eyes twitch	☐	☐	☐
Pain in or around eyes	☐	☐	☐
Eye redness	☐	☐	☐
Burning eyes	☐	☐	☐
Watery eyes	☐	☐	☐
Itchy eyes	☐	☐	☐
Brightness is bothersome	☐	☐	☐
Motion sickness / car sickness	☐	☐	☐
Headaches	☐	☐	☐
Blurred vision	☐	☐	☐
Difficulty changing focus far to near	☐	☐	☐

	Yes	No	Prior to Injury?
Double vision	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
Movement of objects in the environment is bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Patterned wallpaper or carpets are bothersome	☐	☐	☐
Head moves when reading	☐	☐	☐
Lose place often when reading	☐	☐	☐
Words jump or move around when reading	☐	☐	☐
Short attention span for reading or writing	☐	☐	☐
Skip words frequently when reading	☐	☐	☐
Discomfort when reading	☐	☐	☐
Loss of interest/concentration when doing close work	☐	☐	☐
Orient writing/drawing poorly on page	☐	☐	☐
Squinting, covering or closing one eye	☐	☐	☐
Head tilts during desk work	☐	☐	☐
Hold books too close	☐	☐	☐
Avoid reading or writing	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision / Loss of visual field	☐	☐	☐
Flashes of light	☐	☐	☐
Difficulty with dressing	☐	☐	☐
Difficulty with bathing / personal hygiene	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐
Dislike heights	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Dizziness	☐	☐	☐
Confusion / disorientation	☐	☐	☐
Get lost often	☐	☐	☐
Bothered by noises	☐	☐	☐
Bothered by touch	☐	☐	☐
Difficulty remembering things heard	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐
Difficulty remembering name of objects	☐	☐	☐
Difficulty remembering people’s names	☐	☐	☐

	Yes	Prior to No	Injury?
Difficulty recalling information known in the past	☐	☐	☐
Difficulty remembering formerly familiar people / objects	☐	☐	☐
Difficulty performing tasks formerly easy / routine	☐	☐	☐
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Difficulty counting money	☐	☐	☐

Why do you feel the need for a vision evaluation today? ________________________

____
____
____
____
____

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					

LIFESTYLE

Do you feel your vision interferes with activities of daily living? Yes ☐ No ☐

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships): ____

____

____

What activities comprise the majority of your daily life since your accident/injury? ___________

____

____

____

What activities can you no longer engage in due to your visual or other difficulties? __________

____

____

____

What other changes/limitations in your daily life do you attribute to your accident/injury? ______

____

____

____

What do you hope a Visual Rehabilitation Program can do for you? ______________________

____

____

____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is current employment position? ________________________________
If a student, what is the major course of study? __________________________
How many hours daily are spent at a desk? _____________________________
How many hours daily are spent working at near distance? ___________________
How many hours daily are spent reading/studying? _________________________
How many hours daily are spent with a computer? __________________________
How many hours daily are spent in front of a digital device (smartphone/tablet)? ___________

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 specialized testing due at the time of the evaluation. I am aware that should visual therapy / visual enhancement training be recommended, that there may be a wait list for starting the therapy.

____
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 and to better meet your specific visual needs.

<u>Results will be provided verbally after the evaluation. No written report is included in the evaluation fee.</u> 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

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