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

# TBI / Post-Concussion / VISUAL INFORMATION PROCESSING PRE-EXAM QUESTIONNAIRE - ADULT

Please fill out this questionnaire carefully 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 | No | Prior to 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 yourself. How often do you 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? _______________________

### RELEASE OF INFORMATION

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

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

___________________________________________ ____________________

Signature Date

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.

_____________________________________________ _________________

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.

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 visual status. We ask that you find alternate arrangements for looking after any children to prevent unnecessary distractions. Please ensure that you have a good night's sleep the night before the appointment and have 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**