CALGARY VISION THERAPY
Suite 130 – 2880 Glenmore Trail SE, Calgary, AB 403-242-1800

BRENT W. NEUFELD, O.D.
Clinical Director

INFANT/TODDLER VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. This form must be returned to our office at or prior to your scheduled appointment. THANK YOU.

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
Delivery Due Date: _____
Alberta Health Care #_____

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?

_____
_____
_____

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?

_____
_____
_____

Please list the names and birth dates of your family:

NAME

Father/Caretaker _____ Birth Date _____
Mother/Caretaker _____ Birth Date _____
Siblings _____ Birth Date _____
Siblings _____ Birth Date _____
Siblings _____ Birth Date _____
Siblings _____ Birth Date _____

RESPONSIBLE PERSON INFORMATION

Home Address: _____ City:_____ Postal Code: _____
Home Phone: _____ Business Phone: _____
Email: _____
Father/Caretaker's Occupation: _____ Business Phone: _____
Mother/Caretaker's Occupation: _____ Business Phone: _____

MEDICAL HISTORY

Pediatrician's Name: _____ Date of Last Evaluation: _____

For what reason? _____

Results and recommendations: _____

_____

Medications currently using, including vitamins and supplements: _____

_____

_____

For what condition(s)? _____

_____

_____

Immunizations child has received and dates:

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

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

_____

List illnesses, bad falls, high fevers, etc.:

Age 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: _____

Has a neurological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

_____

_____

Has a psychological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results and recommendations:_____

_____

_____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐

By whom? Results and recommendations: _____

_____

_____

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: _____

_____

DEVELOPMENTAL HISTORY

Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
_____
Normal birth? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
_____
Birth weight: _____
Apgar scores @ birth: _____ After 10 minutes: _____
Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) Yes ☐ No ☐
If yes, explain: _____
Any problems with colic? Yes ☐ No ☐
Was there ever any reason for concern over your child's general growth or development? Yes ☐ No ☐
If yes, why? _____
_____
Has your child received any special developmental guidance/ assistance? Yes ☐ No ☐
If yes, explain: _____
_____
How many hours daily does your child sleep? _____
Does your child sleep through the night? Yes ☐ No ☐ If yes, starting at what age: _____
If no, explain: _____
What percent of the waking hours is/was your child in a playpen? _____
In a walker? _____
In a seat? _____
In a bucket car seat? _____
What things can your child do very well? _____
_____
_____
What things, if any, are difficult for your child? _____
_____
_____

NUTRITIONAL INFORMATION

Current Diet: Nursed ☐ Nursed until what age: _____ Bottle fed ☐
Solid food started at what age: _____ What type? _____
Are there any food allergies/sensitivities? Yes ☐ No ☐
If yes, what: _____
Activity Level: High ☐ Moderate ☐ Low ☐
Are there periods of very high energy Yes ☐ No ☐
Are there periods of very low energy? Yes ☐ No ☐
Does your child: Like sweets ☐ and/or Crave sweets ☐
If so, what? _____
What are his/her favorite foods? _____
What are his/her disliked/avoided foods? _____

VISUAL HISTORY

Why do you feel your child needs a visual examination? _____
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? _____
Was surgery, therapy or other treatment recommend? Yes ☐ No ☐
If yes, what? _____

Members of the family who have had visual attention and the reason:

Name / Relationship	Age	Visual Situation

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	Yes	No	If yes, when?
An eye turns in or out	☐	☐	
Reddened or encrusted eyelids	☐	☐	
Frequent sties	☐	☐	
Eyes in constant motion	☐	☐	
Eyelids droop	☐	☐	
Stares at bright lights or repeatedly flicks objects in front of face	☐	☐	
Is abnormally bothered by bright light	☐	☐	
Seems visually unaware	☐	☐	
Has watery eyes	☐	☐	
Turns head to use one eye only	☐	☐	
Tilts head to one side	☐	☐	
Moves objects very close to look at them	☐	☐	
Squints while looking at objects	☐	☐	
Blinks excessively	☐	☐	
Has a tendency to rub eyes	☐	☐	
Covers or closes one eye	☐	☐	
Stumbles over objects or is clumsy	☐	☐	
Poor motor control	☐	☐	
Lacks interest in looking at objects or seeing	☐	☐	
Unable to see distant objects	☐	☐	
Unable to transfer object from hand to hand, or crossing the midline of the body	☐	☐	
Is unable to stack blocks or other objects	☐	☐	

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes ☐ No ☐
If yes, explain: _____

PRE-SCHOOL

******If your child attends preschool, please fill out the following:
Name of Pre-school: _____ Teacher: _____ Director: ____
Age at time of entrance to pre-school: _____
Does your child like pre-school? Yes ☐ No ☐
Does your child like teacher? Yes ☐ No ☐
Compared to other children his/her age, do his/her general performance and social skills seem to be
above ☐ equal to ☐ or below ☐
Please explain: _____
Which pre-school activities are easy for your child? _____
Which pre- school activities are difficult for your child? _____
Specifically describe any pre-school / day care concerns / difficulties: _____
Does your child seem to be under tension at pre-school/day care? Yes ☐ No ☐
If yes, explain: _____

CURRENT ABILITIES/BEHAVIOR

Where appropriate, list the age at which your child could do the following: (some of these behaviors may not apply due to your child's chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach of floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words		Become toiled-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can your child identify colors? Yes ☐ No ☐ If yes, which? _____

Can your child identify numbers or letters? Yes ☐ No ☐ If yes, which? _____

Does your child like to draw/color? Yes ☐ No ☐

Is your child learning to read? Yes ☐ No ☐

How is your child performing as compared to others his/her age:

Above average ☐ Below average ☐

How well developed is your child's spoken vocabulary? _____

How well does your child understand/respond to spoken language? _____

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity	☐	Irritable, easily upset	☐
Thumb-sucking	☐	Restlessness	☐
Nervous	☐	Has difficulty separating from parents	☐
Glum, sulky, moody	☐	Sleeplessness	☐
Bad temper	☐	Lethargic, low energy	☐
Passive	☐	Aggressive	☐

Other (please explain): _____

_____

_____

_____

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?

_____

_____

_____

_____

_____

PLEASE READ AND SIGN THE FOLLOWING:

I have been aware of the cancellation/no show policy: i.e.should you (a family member) cancel the appointment without 48 hours notice, there will be $75 cancellation or no show fee. _____

RELEASE OF INFORMATION
IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my child's examination records to be forwarded 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. 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 of your child and to better meet your child's specific visual needs. If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us 24 hours a day / 7 days a week. We request a minimum of 48 hours notice if you are unable to keep your appointment.

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.calgaryvisiontherapy.com, www.visiontherapy.com , www.covd.org

Thank you,

Brent W. Neufeld, O.D.
Clinical Director