CALGARY VISION THERAPY

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ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully and completely.
This form needs to be returned to our office at your scheduled appointment time.

Date: _____

GENERAL INFORMATION

Full Name: _____ Male □ Female □
Birth Date: _____ Age: _____
Home Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____
Contact email: _____
Alberta Health Care #_____

Were you referred to our office? Yes □ No □
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____

What **specific areas of difficulty** does the **individual referring** feel you may be experiencing?

_____
_____
_____

What specific problems are **YOU** noticing/observing?

_____
_____
_____
_____

How long has this problem/difficulty been observed? _____

What are you hoping to determine through this evaluation? _____
_____
_____
_____

MEDICAL HISTORY
List illnesses, bad falls, high fevers, chronic ear infections, hospitalizations etc:
Age Event Severe / Mild Complications

_____
_____
_____
_____

Are you 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: _____
Family Doctor (circle): _____Date of most recent evaluation: _____
For what problem/condition? _____
Results and recommendations: _____
_____

Current state of health (explain): _____
Medications currently using including vitamins and supplements: _____
_____
For what condition(s)? _____
_____
Are you allergic to any foods or medications? Yes ☐ No ☐
If yes, please list: _____

Is there any **family history** of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	Strabismus / crossed eye	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Blindness	☐	☐	_____	Thyroid Condition	☐	☐	_____
Glaucoma	☐	☐	_____	Cataracts	☐	☐	_____
High blood pressure	☐	☐	_____	Brain Tumor	☐	☐	_____
ADD / ADHD	☐	☐	_____	Learning Disability	☐	☐	_____
Other	☐	☐	_____				

If other, please explain: _____
_____
If ADD/ADHD or a Learning Disability was diagnosed, who diagnosed it, how was it diagnosed and when?
_____
_____

VISUAL HISTORY
Have you had a previous eye examination? 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, what? _____
Do you use them? Yes ☐ No ☐
How long have you had them? _____
If used, when? _____
If not used, why not? _____
If you wear contact lenses, how long have you worn them? _____
What type of lenses do you have (i.e. hard, soft, gas-permeable)? _____
If soft lenses, what brand and strength of powers do you wear? _____
If disposable soft lenses, how often do you throw out your contact lenses and put in your new pair? _____
Do you sleep in your contact lenses? Yes ☐ No ☐
If yes, how many days do you sleep in your contact lenses? _____
What contact lens solutions do you use? _____

IF YOU HAVE HAD AN EYE EXAM IN THE LAST 24 MONTHS, PLEASE CONTACT THAT OFFICE AND HAVE THEM FAX THE LAST EYE EXAM RECORDS TO 403-242-3833 BEFORE YOUR APPOINTMENTS.

PRESENT SITUATION

Do you experience any of the following?	**Yes**	**No**	**If yes, when?**
Blurred vision at distance	☐	☐	_____
Blurred vision at near	☐	☐	_____
Red or itchy eyes	☐	☐	_____
Burning eyes	☐	☐	_____
Frequent Styes	☐	☐	_____
Watery eyes	☐	☐	_____

	Yes	No	If yes, when?
Eyes hurt	☐	☐	
Eyes feel tired	☐	☐	
Headaches	☐	☐	
Nausea associate with visual tasks	☐	☐	
Double vision at distance	☐	☐	
Double vision at near	☐	☐	
Tilt head during desk work	☐	☐	
Squinting, covering or closing one eye	☐	☐	
Postural changes when doing desk work	☐	☐	
Need for very bright light when reading	☐	☐	
Need for very dim light when reading	☐	☐	
Loss of interest or short attention span for close work	☐	☐	
Difficulty sustaining reading/writing	☐	☐	
General or visual fatigue at the end of the day	☐	☐	
Loss of place when reading	☐	☐	
Skip lines when reading	☐	☐	
Repetition of letter or words when reading	☐	☐	
Omission of words when reading / copying	☐	☐	
Use of finger to keep place	☐	☐	
Head moves when reading	☐	☐	
Confusion of what is being seen or read	☐	☐	
Falling asleep when reading	☐	☐	
Silent vocalization/moving lips when reading	☐	☐	
Motion / car sickness	☐	☐	
Difficulty with reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Letters or words appear to move or float around when reading	☐	☐	
Difficulty aligning columns of numbers	☐	☐	
Can respond better orally than in writing	☐	☐	
Write or print poorly	☐	☐	
Poor time management	☐	☐	
Inconsistent performance in work or sports	☐	☐	
Poor general coordination / clumsiness	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulties with short-term memory	☐	☐	
Difficulties with long-term memory	☐	☐	

Comments on any items above or additional items: _____

_____

_____

_____

Place an X in the column that best describes yourself. How often do you experience the following symptoms?

	NEVER	ONCE IN A LONG WHILE (1/month or less)	SOMETIMES (a few times per month)	A LOT (2-3x per week)	ALWAYS (daily)
Blurred vision (near or far)					
Double vision					
Headaches					
Poor working memory					
Burning, stinging, watery eyes					
Falling asleep when reading					
Vision worse at the end of the day					
Skipping or repeating lines or words when reading					
Dizziness or nausea					
Head tilt or closing one eye when completing near work					
Difficulty copying or transitioning sight from far to near					
Concerns with driving ability					
Difficulty reading instructions, maps, or diagrams					
Difficulty with time management					
Mis-aligning digits in columns of numbers					
Reading comprehension declining over time					
Inconsistent/poor depth perception					
Holding reading material too close					
Awkward or poor body balance					
Poor eye-hand coordination (poor handwriting)					
Loss of interest or poor concentration when doing near work					
Avoiding sports and games					
Clumsy, tendency to knock things over					
Difficulty transferring information/data from place to place					

COMPUTERS

How many hours a day do you spend on a computer/laptop: _____
How many hours a day do you spend on a smartphone/tablet: _____
How many hours a day do you play video games (e.g. Xbox, Playstation etc): _____

Do you use a computer in your work, school, or leisure time activities? Yes □ No □
If so, indicate the types of computer work you perform:

- □ Word processing / data entry
- □ Programming
- □ Internet
- □ Games / leisure activities
- □ Research
- □ Other (explain): _____

How do your eyes feel after working at the computer? _____
How do your eyes feel after spending time on your smartphone? _____

Where is the top of the screen located?

- □ Above your straight-ahead eye level
- □ At eye level
- □ Below eye level

What is the distance from: Your eyes to the screen? _____
Your eyes to the keyboard? _____
Your eyes to your source documents? _____

Where is the computer screen located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left

Where are your source documents located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left
- □ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- □ Glare from windows or other light sources
- □ Reflections on your computer screen
- □ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

- □ Glasses
- □ Contact lenses
- □ Other (explain): _____

Please describe any problems you have with your vision, current glasses or contact lenses for computer work:

_____
_____
_____
_____

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____
How many hours daily do you spend at a desk? _____
How many hours daily do you spend reading or studying? _____
How many hours do you spend working at near distances? _____
Do you feel you are achieving to your potential in work or school? Yes □ No □
Do you feel you are getting adequate return for the amount of effort you put into a task? Yes □ No □
If no, please explain: _____
Does your work or course of study demand comprehension from the written word? Yes □ No □
Describe briefly your daily activities at work or in school: _____
_____

HOBBIES / SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____
_____
_____
_____
Do you watch TV? Yes □ No □
If yes, how many hours per day? _____
Are you seriously involved with athletics? Yes □ No □
Do you feel you are achieving up to your potential in sports/athletics? Yes □ No □
Of all the sports you have played:
List the ones in which you excel: _____
List the ones in which you do poorly/avoid: _____

IS THERE ANY OTHER INFORMATION THAT YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR EVALUATION / TREATMENT?

_____
_____
_____

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 Calgary Vision Therapy 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 Signature _____ Date: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Fax: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Fax: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Fax: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Fax: _____

Name: _____ Relation: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Fax: _____

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 exchanged with other health care providers when it is necessary for the treatment of my visual condition. If I was referred by an optometrist, I agree to allow Calgary Vision Therapy send the referring optometrist a summary of the results of the testing along with recommendations given. This authorization shall be valid for the duration of treatment.

_____ _____

Signature or Authorized Representative Date

Cancelling the appointment within 48 hours may have a $75 rescheduling fee. If you do not show up for one of the appointments, there will be a $75 booking fee charged prior to rescheduling the missed appointment.

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.

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 other children (to prevent unnecessary distractions). Please ensure that you have a good night's sleep the night before the appointment and have had something to eat prior to the appointment so hunger will not be a distraction. We are looking forward to meeting you.

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.

Sincerely,

Brent W. Neufeld, O.D.
Palki Arora, O.D. FOVDRA FAAO
Clinical Director

www.calgaryvt.com
https://www.facebook.com/pages/Calgary-Vision-Therapy/335004866603062

**** All appointments with our doctors are at Urban Eye Care Chaparral: #107, 10 Chaparral Drive SE Calgary, AB T2X 3R7 403-453-1211**

**** 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**