

VISUAL INFORMATION PROCESSING and Strabismus/Amblyopia PRE-EXAM QUESTIONNAIRE

Please fill out this questionnaire carefully and completely.
This form must be returned to our office at 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:

<u>Age</u>	<u>Event</u>	<u>Severe / Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____

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)

<u>Patient</u>	<u>Family</u>	<u>Who</u>	<u>Patient</u>	<u>Family</u>	<u>Who</u>
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>
"Cross" eye	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>
Chromosomal Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

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 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:

GLASSES: bifocal OR single vision
Contact lenses
Other Explain: _____

Are they (glasses / contact lenses) used? Yes No
If yes, when are they worn? _____
If no, why not? _____

IF YOUR CHILD HAS HAD AN EYE EXAM IN THE LAST 12 MONTHS, PLEASE CONTACT THAT OFFICE AND HAVE THEM FAX THE LAST EYE EXAM RECORDS TO 403-242-3833 BEFORE YOUR APPOINTMENTS.

At what age did you first notice or suspect that was an eye turning? _____

Did the eye begin turning: Suddenly OR Gradually

Does the eye turn: IN OUT UP or DOWN ? (Check all that apply)

Is the eye turn getting worse or better, or is there no change? _____

Is it always the same eye that turns? Yes No If yes, which eye? Right Left

Is the eye turn always present? Yes No

If no, under what conditions is it present? _____

Does the eye always turn the same amount? Yes No

If no, explain: _____

Does the eye turn less when the prescription is worn? Yes No Unsure

Do you notice if the eye turns more when you look:

Up close? Yes No

In the distance? Yes No

To your left? Yes No

To your right? Yes No

Up? Yes No

Down? Yes No

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

Have you been told that you have amblyopia (lazy eye)? Yes No

Has there been any treatment using an eye patch? Yes No

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: _____

PREVIOUS SURGICAL TREATMENT

Has there been any surgical treatment? Yes No

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results: _____

Was the surgeon satisfied with the results? Yes No Explain: _____

Were you satisfied with the results of the surgery? Yes No Explain: _____

Have surgical results been maintained? Yes No Explain: _____

Are you here for a second opinion regarding surgery? Yes No

PREVIOUS VISION THERAPY TREATMENT

Has there been any visual therapy? Yes No

If yes, Doctor's name: _____

Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision / focus goes in and out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letters/words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head close to paper when reading/writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prefers being read to	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses letter or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skips, rereads or omits words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses place while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vocalizes when reading silently	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes neatly but slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does not support paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Awkward or immature pencil grip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses left and right	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty copying from chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty recognizing same word on different page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor word attack skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Remembers better what hears than sees	<input type="checkbox"/>	<input type="checkbox"/>	_____
Responds better orally than by writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seems to know material, but does poorly on tests	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes / avoids near tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short attention span / loses interest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with scissors / small hand tools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes / avoids sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty catching / hitting a ball	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 (1/month or less)	SOMETIMES (a few times per month)	A LOT (2-3x per week)	ALWAYS (daily)
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 _____
How many hours a day does your child spend on a computer/laptop: _____
How many hours a day does your child spend on a smartphone/tablet: _____
How many hours a day does your child play video games (e.g. Xbox, Playstation etc): _____
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 principals 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 us 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: _____

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 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 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, any of its doctors, and any of their 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

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 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

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.
Palki Arora, O.D. FOVDRA FAAO
Clinical Director

www.calgaryvt.com

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

All appointments with the doctor (binocular coordination evaluation and parent consultation) are at the Urban Eye Care office: #107, 10 Chaparral Drive SE Calgary, AB T2X 3R7 403-453-1211

The Visual Information Processing evaluation is at the Calgary Vision Therapy office with a vision therapist: 4000 Glenmore Court SE, Calgary, AB T2C 5R8 403-242-1800