CALGARY VISION THERAPY
BRENT W. NEUFELD, O.D.
Suite 130 – 2880 Glenmore Trail SE, Calgary, AB 403-242-1800
Clinical Director

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: ____________________
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 vision 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? ______________________________

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

Name	Age	Visual Situation
____________	______	______________________
____________	______	______________________
____________	______	______________________
____________	______	______________________

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	☐	☐	____________
Eyes hurt	☐	☐	____________
Eyes feel tired	☐	☐	____________
Headaches	☐	☐	____________

	Yes	No	If yes, when?
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: ______________________________

____

____

____

COMPUTERS

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
- ☐ Programming
- ☐ Data entry
- ☐ Internet
- ☐ Games / leisure activities
- ☐ Research
- ☐ Other (explain): ______________________________

How many hours do you spend in front of a computer screen each day? ______________________________

How do your eyes feel after working at the computer? ______________________________

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?

____

____

____

PLEASE READ AND SIGN THE FOLLOWING:

I understand that 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 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 Dr. Neufeld 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

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.

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 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.calgaryvisiontherapy.com, www.visiontherapy.com

Sincerely,

Brent W. Neufeld, O.D.
Clinical Director
www.calgaryvisiontherapy.com
https://www.facebook.com/pages/Calgary-Vision-Therapy/335004866603062