Vision Questionnaire – Adult

Date of Appointment:_____

Please take some time to complete this Vision Questionnaire prior to your Visual Evaluation.

Full Name:	**Home Address:**
Date of Birth:	**Home number:**
Occupation:	
Hours on computer	

Emergency Contact 1 :	**Email:**
Cell number:	**Relationship :**
Work number:	**Occupation:**

Emergency contact 2 :	**Email:**
Cell number:	**Relationship:**
Work number:	**Occupation:**

Developmental History: (please circle or answer below)

Family Doctor(name and phone number): _____

_____

_____

Full term Pregnancy? YES NO

Natural Birth OR C-section

Did the mother experience any complications during or after pregnancy? (i.e.- forceps, vacuum assisted delivery etc.) If yes please explain below.

YES NO

Were you in any distress during or after birth? If yes please explain below.

YES NO

Did you crawl as an infant? YES NO

If yes, was it for a short period of time? Were you more interested in standing or walking? At what ages did these developmental phases take place. Please mention if you crawled properly or had a variation of crawling (i.e. army crawl, bum scooting etc.)

Were there any difficulties with gross motor skills as an infant or child? Please describe.

Family and Home:

Please indicate which adult(s) you live with: (circle) Mother Father Stepmother Stepfather Grandmother Grandfather Others

Do you primarily live in one household or split between two households growing up?

Do you have any siblings?

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Is family life stable at this time? Yes No

Have you ever been through a traumatic family situation (such as divorce, family loss, abuse, parental illness or other emotionally traumatic events, etc.)?

Medical History

Describe your current health state.

List of current medications and associated conditions.

As an infant or currently, did you suffer from any chronic problems such as ear infections, asthma etc. Also, describe if you used antibiotics frequently as a child.

Do you have any previously diagnosed special needs conditions such as Autism, ADHD, depression/anxiety etc. Yes No

Name of conditions:_____

Have you hit your head in the past, taken a bad fall, been in a car accident, or suffered from a head injury?

Have you ever had a diagnosed concussion?

Are you currently receiving or been assessed for additional services? What were the results and how often do you attend: (i.e. Speech and Language, Occupational Therapy, Physiotherapist, psychiatric care etc.)

_____

_____

_____

Are you involved in any extra-curricular activities or have any specific hobbies.

_____

_____

******Please observe yourself for a few days prior to answering the questions below******

Please assign a value between 0 and 4 for each symptom.

0= never or non-existent / 1=seldom / 2=occasionally / 3=frequently / 4=always

General (If you don't wear glasses, give yourself a score of 0 next to questions that ask about glasses)

1	Things are blurry for a moment when you look up from reading or computer work	
2	You get headaches or eyestrain when you use your eyes for careful seeing.	
3	Your stomach gets upset after you use your eyes.	
4	Things blur in and out of focus.	
5	It makes you nervous to search the crowded shelves in the grocery store.	
6	Your glasses give you headaches or eyestrain even though you need them to see.	
7	Your glasses make you sick to your stomach.	
8	Since you started wearing glasses you find yourself avoiding reading.	
9	Your glasses keep getting stronger	
10	You would like to become less dependent on glasses	
11	You have glasses, but avoid wearing them as often as possible	
12	Your eye drifts in toward your nose or out toward your ear	

13	For an eye that drifts, you have had surgery the following number of times.	
14	At night, you have difficulty falling asleep.	

General Section Score: _____

Reading

15	When you read, the print blurs	
16	When you read, the print runs together.	
17	When you read, the print looks unsteady or dances.	
18	Reading gives you eye strain or headaches	
19	Reading puts you to sleep.	
20	You avoid reading for fun.	
21	You avoid longer books.	
22	You avoid books with smaller print	
23	When you read, you get the feeling that you'd rather be somewhere else	
24	You rapidly fatigue and lose comprehension when reading	
25	You have to whisper to yourself when reading.	
26	Reading gives you an upset stomach.	
27	You lose your place and skip or reread lines.	
28	You're afraid to read out loud in front of other people	
29	Reading takes too much effort.	
30	You read, "One . . . word . . . at . . . a . . . time."	
31	You have to reread sentences to understand what you are reading.	

Reading Section Score:_____

Driving

32	You get eyestrain or headaches when you drive	
33	You get carsick, especially when sitting in the back seat.	
34	You rapidly fatigue when driving.	
35	You dislike driving at night.	
36	You have difficulty judging how far away other cars are	
37	You find parallel parking difficult	

38	You have to look twice because you can't trust yourself to see things correctly the first time.	
39	You have difficulty telling how fast other cars are moving.	
40	You have trouble seeing road signs.	
41	It makes you nervous to drive when traffic is heavy.	
42	It makes you nervous to drive on the freeway	
43	At night, the taillights ahead of you seem to double up.	
44	You get lost easily when driving.	
45	You worry about driving and limit your activities.	

Driving Section Score:_____

Work

46	You have more trouble with computer and desk work as the day goes on	
47	You have to schedule your computer and desk work in the morning when you're fresh	
48	Your productivity goes down as the day progresses	
49	You get eyestrain or headaches during computer or desk work	
50	Your stomach gets upset during computer or desk work.	
51	You reverse numbers at work, such as seeing 36 for 63	
52	You have to check your work for errors constantly because your eyes play tricks on you.	
53	Your computer or desk work takes longer than it should.	
54	You put off your desk work and instead spend your time talking, either face to face or on the phone.	
55	You'd have second thoughts about a promotion if it meant more reading or desk work.	

Work Section Score:_____

Sports (If a question applies to a sport you don't play, give yourself a score of 0)

56	When you exercise, you prefer walking, running, swimming, calisthenics, or lifting weights rather than visual activities such as baseball, tennis or golf.	
57	When it comes to ball sports, you're a klutz.	
58	You've always avoided participating in ball sports.	

59	It's hard to catch or hit a ball.	
60	When playing golf, your short game is more difficult.	
61	When playing golf, it's not easy to read the green	
62	When playing golf or tennis, you hit long or short	
63	In whatever ball sport you play, it's harder to maintain your concentration the longer the game continues	
64	In any ball sport, you're not as good as your technique would predict.	
65	In tennis you have trouble with returning lobbed shots	
66	In tennis, you have more difficulty at the net than at the baseline.	

Sports Section Score:_____

Coordination

67	It bothers you to walk downstairs	
68	You bump into things.	
69	When dancing, you have two left feet	
70	It makes you nervous to walk in a crowd.	
71	You feel clumsy.	
72	You trip and stumble if you're not careful.	

Coordination Section Score:_____

Relationship

73	You have trouble maintaining eye contact when speaking to someone	
74	You feel like backing further away when a person is speaking to you	
75	You feel as if you need to move right up next to people when they are talking to you	
76	You are too tired to enjoy your friends or family after a day of using your eyes	
77	After a day of using your eyes, you are irritable or short-tempered	
78	Sore eyes or headaches interfere with your relationships	
79	Desk work drags on forever so you have little time left to enjoy your friends or family.	
80	The effort it takes you to read has kept you from going back to school and is therefore limiting your income.	

81	Your worries about driving limits the number of activities in which you or your children get to participate	
82	Your reading ability affects your confidence.	
83	Your driving ability affects your confidence	
84	Your coordination affects your confidence	
85	Having to wear glasses affects your confidence	
86	You're embarrassed to be seen in glasses	
87	You're embarrassed by the appearance of your eye turning.	
88	When you speak with people they don't seem to know which of your eyes to look at.	
89	When you speak with people they look over your shoulder to see where you are looking.	
90	When you speak to people your attention is on holding your eyes straight.	

Relationship Section Score:_____

Scoring Your Results: Add together your scores from all sections

General Section Score _____

Reading Section Score _____

Work Section Score _____

Coordination Section Score _____

Sports Section Score _____

Driving Section Score _____

Relationship Section Score _____

Grand Total: _____

It is important for our eye care facility to understand you as a whole. Below, please give a brief description of you as a person:

_____

_____

Is there any other information you feel would be helpful or important in our evaluation of you?

_____

_____

When pursuing Neuro-Visual Training, what would be your academic and behavioural goals for you?

_____
_____
_____

What goals would you like to achieve with Vision Therapy?

_____
_____
_____

Who are your care providers (family doctor, pediatrician, teacher, speech pathologist)

Name:_____
Office:_____
Type of Practitioner:_____
Phone:_____
Fax:_____
Address:_____

Name:_____
Office:_____
Type of Practitioner:_____
Phone:_____
Fax:_____
Address:_____

Do you consent for the release of the report to other healthcare providers? Yes / No

Signature of Patient_____ _____

PLEASE <u>EMAIL</u> (wardenoptometry@gmail.com) OR <u>FAX</u> (905-940-1326)

THE COMPLETED QUESTIONNAIRE BY_____