Client Information

You are completing the Irlen intake form

Please take a moment to fill out our intake form before your visit. All information is kept completely confidential.

First Name

Last Name

Email

Preferred Name (if different)

Prefix / Title

Please provide at least one phone number:

Mobile Phone:

Home Phone:

Work Phone:

Country

Street Address

City

State

Postal / Zip

Date of Birth

Gender

Employer

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Name of Referring Professional

Referring Professional Phone (if known)

Referring Professional Email (if known)

How Did You Hear About Us?

Please check that all required questions have been answered.

Cancellation Policy

Clients may cancel or reschedule without penalty by notifying us at least _____ hours before their scheduled appointment. To cancel, please contact us at:

Phone: _____

Email:_____

Late Cancellation: Cancellations are considered late when the client does not cancel at least _____ hours prior to the scheduled appointment. Late cancellations may result in a fee.

Missed Appointments: If a client misses their scheduled appointment without cancelling or rescheduling, they may be charged a percentage of the appointment fee.

Questionnaire

Please answer the following to the best of your ability.

Reason for Referral:

- [ ] Reading Problems
- [ ] Learning Difficulties
- [ ] Attention Problems
- [ ] Migraines
- [ ] Headaches
- [ ] Light Sensitivity
- [ ] Depth Perception Problems
- [ ] Visual Disturbances
- [ ] Anxiety
- [ ] Other

How did you find us?

Have you been diagnosed with any of the following conditions?

- [ ] Post-Concussive Syndrome
- [ ] Concussion
- [ ] Traumatic Brain Injury (TBI)
- [ ] Non-Traumatic Brain Injury (stroke, tumor, etc.)
- [ ] Migraine without Aura (MoA)
- [ ] Migraine with Aura (MA) Chronic Migraine Cluster
- [ ] Headaches
- [ ] Attention Deficit Hyperactivity Disorder (ADHD)
- [ ] Autism Spectrum Disorder (ASD)
- [ ] Dyslexia
- [ ] Dysgraphia
- [ ] Dyspraxia / Developmental Coordination Disorder (DCD)
- [ ] Post-Traumatic Stress Disorder (PTSD)
- [ ] Vertigo
- [ ] Anxiety
- [ ] Depression
- [ ] Autoimmune Disorder
- [ ] Photophobia/Photosensitivity
- [ ] Long-Covid
- [ ] Epilepsy/Seizure Disorders
- [ ] Vision Disorder
- [ ] Learning Disabilities
- [ ] None

If you answered yes to any of the above diagnoses, please describe.

If you have not been formally diagnosed but suspect you have any conditions, please explain.

Current Treatments

- ☐ Prescription Medications*
- ☐ Over-the-Counter medications*
- ☐ Supplements/Nutraceuticals*
- ☐ Botox Injections Vision
- ☐ Therapy/Vision Training
- ☐ Vestibular Therapy
- ☐ Acupuncture
- ☐ Chiropractic Care
- ☐ Massage Therapy
- ☐ Healing Touch
- ☐ Neurofeedback/Biofeedback
- ☐ Neurostimulator Device
- ☐ Meditation
- ☐ Marijuana/CBD
- ☐ Sunglasses (worn most of the time)
- ☐ Colored Glasses/Migraine Glasses (like FL-41)
- ☐ Blue-Blocker Lenses
- ☐ Other*
- ☐ None

***Please list current medication, dosage, frequency, and reason.**

Past Treatments- please list when treatment was discontinued

- ☐ Prescription Migraine Medications*
- ☐ Botox Injections
- ☐ Acupuncture
- ☐ Over-the-Counter medications*
- ☐ Vision Therapy/Vision Training
- ☐ Chiropractic Care
- ☐ Supplements/Nutraceuticals*
- ☐ Vestibular Therapy
- ☐ Massage Therapy

- [ ] Healing Touch
- [ ] Sunglasses (worn most of the time)
- [ ] Neurofeedback/Biofeedback
- [ ] Colored Glasses/Migraine Glasses (like FL-41)
- [ ] Neurostimulator Device
- [ ] Blue-Blocker Lenses
- [ ] Meditation
- [ ] Other*
- [ ] Marijuana/CBD
- [ ] None

Vision History

Please note: If you wear glasses or contact lenses, a valid vision prescription is required. It is recommended that all clients see their eye care professional prior to their appointment.

- [ ] **Do you wear a vision prescription?**

If yes, your vision prescription is for:

- [ ] Distance
- [ ] Reading
- [ ] Both

Date of your last vision exam:

Do you have a history of any of the following optical conditions/procedures?

- [ ] Amblyopia
- [ ] Strabismus
- [ ] Nystagmus
- [ ] LASIK
- [ ] PRK
- [ ] Cataracts
- [ ] Other: _____

Symptom Frequency and Severity

Have you seen a doctor about headaches/migraines?

In the last 4 weeks...

How many days did you experience a headache?

How many days did you experience a migraine?

How many days did you take over-the-counter medication for your headache/migraine?

Did you go to the emergency department for your headaches/migraines?

Did you have to receive an emergency injection for your headaches/migraines?

How often are you bothered by the following?

Bright or artificial light (including fluorescents and LEDs)

Never Rarely Sometimes Often Always

Sunlight

Never Rarely Sometimes Often Always

Glare

Never Rarely Sometimes Often Always

Hazy days

Never Rarely Sometimes Often Always

Computer screens or phone screens

Never Rarely Sometimes Often Always

Headlights or streetlights when driving at night

Never Rarely Sometimes Often Always

Reading on bright white paper

Never Rarely Sometimes Often Always

Looking at stripes or other patterns

Never Rarely Sometimes Often Always

In the past month, how often has being in bright or fluorescent lighting caused the following?

Headache

Never Rarely Sometimes Often Always

Migraine

Never Rarely Sometimes Often Always

Eyestrain or pain

Never Rarely Sometimes Often Always

Fatigue

Never Rarely Sometimes Often Always

Stomachache or nausea

Never Rarely Sometimes Often Always

Irritation or agitation

Never Rarely Sometimes Often Always

Feeling anxious, antsy, or fidgety

Never Rarely Sometimes Often Always

Difficulty concentrating

Never Rarely Sometimes Often Always

Difficulty reading

Never Rarely Sometimes Often Always

Performance to deteriorate over time

Never Rarely Sometimes Often Always

Education History

Are you currently a student?

What grade/level?

☐ Private ☐ Public ☐ Homeschool ☐ Charter ☐ Other: _____

Please provide the name of your school and course of study.

Please describe any past or current academic problems.

As a whole, how would you rate yourself academically?

☐ Struggling ☐ Average ☐ Above-Average

Current Special Assistance (please describe)

☐ Tutoring

☐ Sensory-Motor Integration Therapy

☐ Speech-Language Therapy

☐ Occupational Therapy

☐ Counseling

☐ Remedial Reading

☐ Special Education

☐ Psychoeducational Testing

☐ Other

Consents

Accuracy of Information

☐ I certify that the above information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated professionals to communicate with my referring provider as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree

Cancellation Policy

Your appointment time is reserved just for you. As such, we require notice for any cancellations or changes to your appointment. Clients who do not provide appropriate notice or miss their appointment may be charged a cancellation fee. Please review the full policy on page one of this form.

☐ I am aware of the Cancellation Policy

Video/Photo Release

I authorizes Perceptual Development Corporation (PDC) to use pictures of me (or my child) taken in a photograph, digital image, videotape, motion picture, and/or testimonial (written words), hereafter referred to collectively as material. I also acknowledge that I will receive no compensation for the use of this material.

I also grant permission for said material to be used on YouTube, Facebook, Pinterest, Irlen Website, Irlen Newsletter, other social media, or any other publication.

○ I consent.

○ I do not consent.

Consent for Research

I give permission for all information from my Irlen Screening and/or IDPS appointment to be used for research purposes, including my symptoms, severity scores, and spectral filter colors. This may also include information reported on my Irlen self-test and information from my intake questionnaire. I understand that all personal information will be kept confidential, and no personal identifiers (such as name or contact information) will be gathered or stored as a part of any research conducted. All research results will be presented in aggregate, meaning that you will not be identified in any way in any papers, reports, or presentations given to share the results from any study using your testing data. Allowing researchers to use your testing data in future research will not benefit you directly, but we hope to learn things to benefit others and further the understanding of Irlen Syndrome.

○ I consent.

○ I do not consent.