CLIENT INFORMATION PROFILE
IRLEN CENTRE VANCOUVER ISLAND

Please complete this form so I can better understand your situation and how I can help.

Today's Date: ________________________

Name of client: _____________________________________ **M F**

Date of Birth: _____________________ **Age:** ______ **Grade:** _______

Date of latest eye exam: _______________________________

Were corrective lenses prescribed? Y N Are they worn regularly? Y N

Mailing Address: ____

_________________________________ **Phone:**________________________

Email address: ____

Is this a recent condition? Y N Since when? ________________________

Has there been a trigger of some sort? (trauma, illness, stress, brain injury)

Please briefly describe the client's academic history. (learning challenges, areas of struggle, any support required or received, assessments, etc.)

Are there any physical reactions that are attributed to the environment? (headaches from bright lights, sound or scent sensitivities, depth perception)

Please explain how and why you were drawn to explore Irlen Syndrome?

Were you referred? Y N By whom? ________________________________

What are you hoping the Irlen screening might accomplish for you?

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