

CLIENT INFORMATION PROFILE
IRLEN CENTRE VANCOUVER ISLAND

Now that you have forwarded me your Irlen self-test from www.irlen.com, 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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