



SENSORY
LEARNING
CENTER™

Neuro Vision Rehabilitation Institute

(Division of Family Vision Care Optometry, Inc.)

Drs. Carl Garbus, James Yi,
Andrea Woo & Mariya Berkovich
28514 Constellation Road
Valencia, CA 91355
Phone: 661 775-1440
Website: FVCOptometry.com

POST-SESSION SENSORY LEARNINGSM PROFILE

This information will be treated confidentially.

Patient's Name: _____ **Date:** _____

We would like this form to give us a present overall picture of the patient after completing the Sensory LearningSM Program. This information helps us to give parents reasonable expectations.

Contact Information

Contact's Name: _____ Relationship: _____

Address: _____

City: _____ Zip: _____

Phone: _____ E-mail: _____

Patient Date of Birth: _____

Please tell us about changes in your speech and language development. (i.e. non-verbal, articulation issues, conversational skills, etc)



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Please describe any changes in auditory issues. (i.e. sensitivities, receptive language skills, understanding verbal multi-step directions, etc)

Please describe any changes in visual issues. (i.e. light sensitivity, eye tracking problems, glasses/contacts, quality of eye contact, etc)

Please describe any changes in vestibular/ motor issues. (i.e. low muscle tone, poor balance, gravitationally insecure, tactile defensiveness, poor coordination)



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Please share any changes in medications that you are taking?

Please describe any changes in your overall behavior. (i.e. overwhelmed easily, aggressive tendencies, frequent tantrums, ability to express emotions, obsession with routine and repetitive patterns, hyper active, etc)



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Benefits realized from participating in the Sensory Learning™ Program

Please elaborate in the following areas:

1. Activity Level/Sleep Patterns:
2. Sensory Integration/Motor Skills:
3. Speech/Language Skills:
4. Perceptual/Cognitive Skills:
5. Personal/Social Skills:
6. Emotional/ Behavioral Changes:

Additional comments-