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**Kansas City Vision Performance Center**  
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**Student History Form**

**GENERAL INFORMATION**

Child's Full Name \_\_\_\_\_ Goes by: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Guardians: \_\_\_\_\_

Child Resides With: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Email: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Email: \_\_\_\_\_

School Name & Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Teachers Name: \_\_\_\_\_

Child's grade in school: \_\_\_\_\_

How did you hear about our center? \_\_\_\_\_

**PRESENT SITUATION**

Why do you wish to have your child evaluated? \_\_\_\_\_

List any complaints your child makes concerning his/her vision: \_\_\_\_\_

At what age did the problem begin and under what circumstances: \_\_\_\_\_

Has the problem become better or worse? \_\_\_\_\_ Explain: \_\_\_\_\_

Does anyone else in the family have a similar problem? \_\_\_\_\_

Has there been any previous treatment? \_\_\_\_\_

Does the child feel that he/she has a problem? \_\_\_\_\_

If yes, what is the child's attitude toward the problem? \_\_\_\_\_

### **MEDICAL HISTORY**

List any illnesses, seizures, accidents, surgeries, fevers, etc. That the child has experienced:

<b>Illness/Injury</b>	<b>Age</b>	<b>Type of Severity</b>	<b>Complications (if any)</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any prescription or over-the-counter medication(s) being taken, dosage, name reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health at present:   **Excellent**   **Good**   **Fair** **Poor**

Does the child suffer from any chronic problems such as asthma, colds, allergies or ear infections? \_\_\_\_\_

When was your child's last eye exam? \_\_\_\_\_

Clinic name and address: \_\_\_\_\_

Were glasses recommended at any of their previous vision examination(s)?   Yes   No

Were treatment recommendations made?   Yes   No, If yes, explain: \_\_\_\_\_

Was the treatment program followed?           Yes   No

Was the treatment effective?                    Yes   No

Has a vision therapy program ever been recommended?   Yes   No

    o If yes has the program been completed?   Yes   No

Members of the family who have had vision treatment and why?

<b>Name</b>	<b>Age</b>	<b>Visual Condition/Treatment</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any indications of hearing or speech-related problems?   Yes   No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

### **DEVELOPMENTAL HISTORY**

List any medications taken or complications during pregnancy:

Length of pregnancy: \_\_\_\_\_   Natural or C-Section: \_\_\_\_\_

Complications before, during or following delivery: \_\_\_\_\_

\_\_\_\_\_

Did you child crawl (stomach on floor)?   Yes   No   At what age? \_\_\_\_\_

On hand and knees?                            Yes   No   At what age? \_\_\_\_\_

Was there anything unusual about crawling or early motor development? \_\_\_\_\_

At what age did your child walk? \_\_\_\_\_  
 Did arm or legs require braces? Yes No  
 Which hand does your child use for Eating? \_\_\_\_\_ Writing? \_\_\_\_\_  
 Throwing? \_\_\_\_\_  
 Has he/she always used the same hand? Yes No  
 Was any guidance given? Yes No  
 Which foot does he/she use for kicking? \_\_\_\_\_ Hopping? \_\_\_\_\_  
 Your child's first words were at age: \_\_\_\_\_  
 Was early speech clear to others? Yes No  
 Is it clear now? Yes No

**GENERAL BEHAVIOR**

Does he/she actively participate in play, sports, or athletics? Yes No  
 Which ones? \_\_\_\_\_  
 Does he/she enjoy music? Yes No  
 Can he/she carry a tune? Yes No  
 Can he/she keep rhythm? Yes No  
 Are there any behavior problems? Yes No  
 If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 What causes these problems? \_\_\_\_\_  
 \_\_\_\_\_

**EDUCATIONAL HISTORY**

Age at time of entrance to: Kindergarten: \_\_\_\_\_  
 First grade: \_\_\_\_\_  
 Does your child like school? \_\_\_\_\_  
 Does your child like the teacher? \_\_\_\_\_  
 School work is: Above average Average  
 Below average Well below average  
 Do you feel that he/she is working up to his/her potential? \_\_\_\_\_  
 Specifically describe any school difficulties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 What subjects are easy for your child? \_\_\_\_\_  
 \_\_\_\_\_  
 Possible reasons for difficulties? \_\_\_\_\_  
 \_\_\_\_\_  
 Has a grade been repeated? \_\_\_\_\_ If yes which grade? \_\_\_\_\_  
 Does your child attend any special need classes? Yes No  
 If yes, explain: \_\_\_\_\_  
 Has attendance been regular? Yes No If no, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 Does your child like to read? Yes No Voluntarily? Yes No  
 If yes, what? \_\_\_\_\_  
 Does your child read on his/her own? Yes No  
 Does your child prefer to be read to? Yes No  
 What is your child's present reading level (by grade level definition)? \_\_\_\_\_  
 Has your child ever been classified as ADD, ADHD, LD, dyslexic, or any other diagnosis?  
 Yes No

Please list any psychological or educational tests performed: \_\_\_\_\_

**HOME ENVIRONMENT**

Who lives in the home? Please give ages, gender, and relationship to the child:

Name	Age	Gender	Relationship to the child
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Additional home information we should know (frequent moving, separation, divorce, remarriage, death, etc.) \_\_\_\_\_

Previous nursery or other group experiences (Sunday school, camp, daycare, etc.): \_\_\_\_\_

**INTERESTS AND HOBBIES**

Does he/she have any special abilities (art, music, etc.)? \_\_\_\_\_

Favorite activities-what does you child find most rewarding? \_\_\_\_\_

Give a brief description of your child's personality: \_\_\_\_\_

**RELEASE**

The doctor in our clinic specializes in the diagnosis and treatment of functional vision problems. Our clinic does visual efficiency and visual information processing evaluations.

**The doctor in our clinic does not perform primary-care eye health exams.** We do recommend that you have an eye health exam yearly by a primary-care optometrist. If we require you to have this exam prior to your visit with our doctor we will let you know. If you would like a list of primary care optometrists please let us know.

I understand that the doctor will not be assessing my child's eye health in the course of his/her evaluation. I further understand that it is recommended that I have an eye health examination yearly by a primary-care optometrist. I agree to allow Kansas City Vision Performance Center to send the records from my exam to my primary care optometrist. If you have not had a primary eye health exam the previous statement is not applicable.

\_\_\_\_\_  
**Signed (patient or parent if patient under 18)**

\_\_\_\_\_  
**Dated**

**DISCLAIMER**

The developmental vision evaluation and report consultation are completed at no charge. No strings attached. We are committed to providing quality developmental vision testing so patients and their families can learn about their possible vision needs, beyond a routine 20/20 eye exam. Providing the testing free of charge removes a significant barrier to those seeking information about this unique and valuable area of vision care.

A summary of the testing, along with diagnosis information and recommendations from the doctor are provided during the consultation for you, the referring doctor and other professionals. We are also glad to provide letters of predetermination for insurance and copies of reports for referring doctors or other professionals.

If records or reports, beyond what is provided during the consultation, are requested by non-returning patients or for use outside of our office, this requires us to charge for both the evaluation and expanded report at our customary fee of \$600.