Dr. John Metzger, OD
Kansas City Vision Performance Center
Developmental Optometry, Vision Therapy, Low Vision Rehabilitation & Neuro-Optometry
10875 Grandview Dr., Ste. 2260, Overland Park, KS 66210
913 – 469 – 8686

Thank you for scheduling a developmental vision evaluation at our office. **Please plan for the evaluation to last 90 minutes.** You will receive the test results and recommendations on a separate date, along with a results summary and folder of information. The report consultation will last about 30 minutes and is only for parents and caregivers**.**

Both the 90 minute evaluation and report consultation is completed at no charge. We do this to educate patients' families about our special area of vision care. Most offices charge between $200 and $600 for this specialized type of testing.

Since we do the testing at no charge, testing appointments are limited. Someone may be waiting for your space. **We kindly ask that you call 24 hours in advance if you need to reschedule or cancel your appointment.**

It is also important for you to understand the cost of this specialized service. If you choose to start a treatment program, vision therapy is sometimes covered under medical insurance. However, it is frequently an out-of-pocket expense. Typical therapy program fees can be similar to the cost of braces for the teeth. Also, therapy visits are generally once a week for 50 minutes. That said, we do customize each program to fit the needs and abilities of the patient and family.

We look forward to having you visit our office and learn first-hand about developmental optometry and how vision affects reading, learning and school success.

Sincerely,

Dr. John C. Metzger & Staff

John C. Metzger, OD
Vision Therapy & Low Vision Rehabilitation
11248 Strang Line Rd., Lenexa KS 66215
(913) 469-8686 www.visiontherapykc.com

Pre-Kindergarten History Form

GENERAL INFORMATION

Child's Full Name______________________________ Goes by: __________
Street Address: ____
City_______________________ State: ___________ Zip: ____________
Home phone # ___________________ Child's Age: ________________
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: ______________________________________
(if applicable) ______________________________________
____

Teachers Name: ______________________________________
Child's grade in school: ______________________________________

How did you hear about our center? ________________________________
Who is your medical insurance carrier?_____________________________

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? ____
____
Members of the family who have had visual treatment and why:

Name	Age	Visual Condition/Treatment

MEDICAL HISTORY

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

Illness/Injury	Age	Type of Severity	Complications (if any)

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? ____

Are there any indications of hearing or speech-related problems? Yes No
If yes, explain: ____
____

When was your last eye exam? ____
Clinic name and address:____

Were glasses recommended at any of their previous vision examination(s)? Yes No
At what age were they first worn?__________

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
- If yes has the program been completed? Yes No

Does your child verbalize any problems/complaints about his/her vision Yes No
If yes, explain:____
Last Medical Exam was on ____/____/_____ Doctor:_____________________________

Current Medications (dose and reason for taking):_________________________________
____

Immunizations up to date? Yes No
Any Reactions to Immunizations:____
____

DEVELOPMENTAL HISTORY
List any medications taken or complications during pregnancy:
____
____
____
Length of pregnancy: ______________ Natural or C-Section: ______________________
Complications before, during or following delivery: ________________________________
____
____

What percent of the waking hours is/was your child in a play pen?__________________
In a walker?____________________ In a seat?____________________________________

Did your child have a coordinated crawl and creep before he/she walked? Yes No
Did your 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 doe 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
How well developed is your child's spoken vocabulary?_________________________
____
How well does your child understand/respond to spoken language?_______________
____

How is your child performing as compared to others his/her age?
Average Above Average Below Average

Was there ever any reason for concern over your child's general growth or development?____

Has your child received any special developmental guidance/assistance? Yes No
If yes, explain:____
____
What things can your child do very well? _______________________________________
____
What things, if any, are difficult for your child?___________________________________
____
Can your child identify colors? Yes No If yes, which? ________________________

Can your child identify numbers? Yes No Letters? Yes No
Does your child like to draw/color? Yes No
Is your child learning to read? Yes No

General Growth/development: Normal Delayed
Has your child undergone any of the following testing/treatment?
Educational: Yes No **Neurological:** Yes No **Psychological**: Yes No
Occupational: Yes No **Speech/Auditory:** Yes No **Physical**: Yes No
If yes, please list all previous evaluations done on your child:

Doctor/Institution	Date(s)	Type of Evaluation	Results/Treatment

HOME ENVIRONMENT
Who lives in the home? Please give ages, gender, and relationship to the child:
Name **Age** **Gender** **Relationship to the child**
____
____
____
____

Additional home information we should know (frequent moving, separation, divorce, remarriage, death, etc.)____
____
____

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

Give a brief description of your child's personality: _____________________________
____

Is there any other information that would be helpful/important in our evaluation or treatment of your child?____
____

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 Vision Therapy KC 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 (Our lawyer made us do it.)

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.