John C. Metzger, OD, LLC
KC Vision Performance
Vision Therapy • Neuro-Optometry • Low Vision Rehab
10875 Grandview Dr., Ste. 2260, Overland Park, Kansas 66210
(913) 469-8686 kcvisionperformance.com

Child History Form

GENERAL INFORMATION

Today's Date:_____

Child's Full Name	DOB
Goes By	
Home Address	
City	State + Zip
Home Phone	
Primary Caregiver	Occupation
Cell Phone	Work Phone
E-mail	
Spouse/2nd Caregiver	Occupation
Cell Phone	Work Phone
E-mail	
Other Active Guardians (Step parents, Grandparents etc.)	
Child Resides With	
Name of School	
How did you hear about us?	

Insurance Provider (Please see last page to give this information if you are Original Medicare or BCBS)

CHILD'S OVERALL HEALTH

On a scale of 1 to 10, how would you rate your child's overall health? (10 = Excellent)

Please describe any past or current health problems your child has experienced.

Has your child had reactions to any immunizations or medications? Yes No

If yes, please describe:

Please bring a list of your child's current medications to the appointment.

Please list any allergies your child has to medications.

CHILD'S DEVELOPMENTAL MILESTONES

Please check all symptoms below that apply.

Normal	Delayed	
_____	_____	Crawling
_____	_____	Walking
_____	_____	Hearing
_____	_____	Speech

YES	NO	
_____	_____	If speech was delayed, can he/she speak clearly now?
_____	_____	Does your child understand and respond to spoken language?
_____	_____	Does your child feel like he/she has a problem?
_____	_____	Can your child keep a rhythm?
_____	_____	Does your child like to read?
_____	_____	Does your child like to be read to?
		Can your child identify:
_____	_____	Colors
_____	_____	Letters
		Numbers

What is your child's dominant hand?

Left Right Ambidextrous

Is your child color blind?

Yes No Don't know

Has or does your child receive special development assistance?

OT PT Speech

Other _____

Grade level your child reading at: _____

What activities does your child participate in?

____ Dance ____ Music

____ Gymnastics ____ Art

____ Martial arts ____ Theater

____ Sports ____ Other

Current grade in school? _____
(Or grade that was most recently completed)

Grade(s) repeated? _____

Please describe the child's home environment, such as who lives in the home?

Please share any additional home/environmental changes we should know about (frequent moving, separation, divorce, remarriage, death, etc.)

Please describe any behavioral problems at home.

Is your child having difficulty at school? If yes, please describe.

American *Recovery* and Reinvestment Act (ARRA) Information Requested:

(This information is optional. These categories are requested by the federal government):

Race: ___ African American or Black___ American Indian/Alaskan Native___ Asian ___ Native Hawaiian/Pacific Islander ___ White___ Other ___ Declined

Preferred Language: ___ English, ___ Spanish, Other:_____ ___ Declined

Ethnicity: ___ Hispanic or Latino, ___ Not Hispanic or Latino ___ Declined

Smoking Status: ___Current Everyday Smoker ___Current Some Day Smoker ___Former Smoker ___Never Smoker ___ Smoker, Status Unknown ___ Unknown If Ever Smoked

Received Influenza Immunization: ___ Yes ___ No ___ Declined

RELEASE

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 or ophthalmologist. 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 or ophthalmologists please let us know.

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

_____ _____

Signed (Patient or Parent if patient under 18) **Date**

30 QUESTION PREDICTIVE CHECKLIST

TO REVEAL POTENTIAL VISION PROBLEMS

NAME____ _____ AGE _____ DATE_____

After you consider each question, mark the column that applies to the person you are assessing.

0 = Never 1 = Seldom 2 = Occasional 3 = Frequently 4 = Always

Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page (See example on other side.)	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is “I can’t” before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	
20-24 points = Suspect 25 points or more = Refer for care				**TOTAL SCORE**		

This predictive checklist was developed by optometrists and educators for the College of Optometrists in Vision Development (www.covd.org).

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Insurance Information

We only participate in BlueCross BlueShield and Original Medicare (plus your Insurance Supplement).

Patient Name

Subscriber Name

Subscriber DOB

Relationship to Patient

Primary Insurance Plan

Primary Subscriber ID#

Secondary Insurance Plan

Secondary Subscriber ID#

Is Subscriber Billing Address the same as the Patient Billing Address? Yes No

If No, please enter Subscriber Billing Address

Address

City State + Zip