John C. Metzger, OD
Vision Therapy & Low Vision Rehabilitation
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Adult History Form

GENERAL INFORMATION

Full Name_________________________________ Goes by: ___________

Street Address: ____

City_______________________ State: ____________ Zip: _____________

Date of Birth_____________________________ Age: _________________

Occupation:____________________________

Home Phone: ____

Cell phone: ____

Work phone: ____

Email: ____

Spouse's Name: ____

Spouse's Occupation: ____

Cell phone: ____

Work phone: ____

How did you hear about our center? ________________________________

Who is your medical insurance carrier?______________________________

PRESENT SITUATION

Why do you wish to be evaluated? _______________________________________
____

List any complaints you have concerning your 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? ___________________________
____

MEDICAL HISTORY

List any illnesses, seizures, accidents, surgeries, fevers, etc that you have 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**

When was your last eye exam? ____
Clinic name and address:____
Were glasses recommended at any of your 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
- If yes has the program been completed? Yes No

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

Name	Age	Visual Condition/Treatment

List any complications or abnormalities surrounding your mothers' pregnancy and your birth: ____
____

List any developmental delays as a child (crawling, walking, etc):_____________________
____
____

EDUCATIONAL HISTORY

Highest grade completed in school:____________ Did you enjoy school? YES NO

Specifically describe any school difficulties you experienced:______________________
____
____

Do you like to read? Yes No

Would you rather be read to than read by yourself? Yes No
What do you enjoy reading?____

Have you ever been classified as ADD, ADHD, LD, dyslexic, or any other diagnosis?
Yes No If so, what?____

Are you taking any medication for any of these conditions?: YES NO
If so, what?____
____

INTERESTS AND HOBBIES

What hobbies and activities do you most enjoy?_________________________________
____

What hobbies and activities do you least enjoy?_________________________________
____

Are you involved in any organized sports activities or teams? YES NO
If so, what?____

Do you enjoy music? YES NO Do you play a musical instrument? YES NO
If so, what?____

Can you carry a tune? YES NO Can you maintain rhythm when dancing? YES NO

Briefly describe your 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 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.