The Hearing Center

Case History for Auditory Processing Assessment in Children

If your child has an IEP, 504 Plan or any other educational service plan, please bring to your child's appointment. In addition, any outside reports such as audiological, speech, educational, psychological, occupational therapy or physical therapy, should be brought to the appointment as well.

Please complete this history form at home and bring it with you to your child's visit. This will save you time so we can spend more individualized time with you and your child. Thank you!

Patient's Name:_____ Date:_____
Person Completing this form:_____Relationship:_____
Person who recommended this testing:_____
What are your concerns that bring you here?_____
_____
_____
_____
Has your child ever been evaluated for diagnosed with an Auditory Processing Disorder? Y/N
When?_____Where?_____
Please bring a copy of that report to your child's evaluation.

Medical and Hearing History:

	YES	NO
Do you have any concerns about your child's hearing?	☐	☐
Does anyone in your child's immediate or extended family have hearing loss that began before the age of 30?	☐	☐
Has your child ever had tubes? ● When?_____ ● Where?_____	☐	☐
Does your child consistently respond to loud noises?	☐	☐
Does your child consistently respond to your voice?	☐	☐

Is your child able to locate the source of a sound? ☐ ☐

Do you feel that your child has a problem listening or understanding? ☐ ☐

Has your child had their hearing tested before? ☐ ☐
- When?_____
- Where?_____
- Results?_____

Is your child in good general health? ☐ ☐

Where there any complications during pregnancy? ☐ ☐

Where there any illnesses or medications during pregnancy? ☐ ☐

Where there any complications during delivery? ☐ ☐
- Birth Hospital_____
- Birth weight_____
- APGAR Scores_____and_____

Did you child pass the Newborn Hearing Screening? ☐ ☐

After birth: ☐ ☐
- Did your child require any assistance breathing?
- Did you child have any issues feeding?
- Did your child require any blood transfusions?
- Did you child need to take any medications?

Is there a history of recurrent ear infections? ☐ ☐

Is your child taking any medications? ☐ ☐
- What (please include dosage and frequency)?

_____
_____
_____
_____

Any surgeries? Please explain._____ ☐ ☐
_____
_____

Any history of head trauma or concussions? Please explain._____ ☐ ☐
_____
_____

Any additional hospitalizations or illnesses? Please explain._____ ☐ ☐
_____

_____

Developmental History:

Has your child been evaluated and/or received therapy for:

_____Physical Therapy _____Occupational Therapy _____Speech Therapy
_____Visual Therapy _____Developmental delays _____Reading problems
_____Mental Delays _____Attentional disorders (ADD/ADHD)
_____Other (Please Explain)_____

Please note dates/therapy received, duration of therapy and professional performing therapy.

_____
_____
_____
_____

If you marked yes to ADD/ADHD:

Who diagnosed your child and when?_____		
Was medication recommended?	YES	NO
Is your child currently taking the recommended medication? ● Type_____ ● Dosage_____ ● Frequency_____	YES	NO

School attending currently:_____
Grade currently in:_____Had your child ever repeated a grade? Y/N
Has your child been evaluated by the Child Study Team? Y/N When?:_____
Does your child have an Individualized Education Plan (IEP) or 504 Plan in place? Y/N
Which one? IEP/504 Plan What kind of services in place?_____
Please bring a copy of the most current IEP or 504 Plan.
Any Basic Skills Classes, Resource Classes or In-Class support? Y/N
Which courses, which support service and how often?_____

_____
_____
_____

Does your child have any accommodations in place (i.e. extended test time)?_____

_____
_____
_____

Does your child like school? Y/N Favorite subjects:_____
Subjects struggling the most with_____
Does your child use an FM system in school? Y/N What kind? Personal/Soundfield/Other
How is your child performing in school:_____

_____

Is there a family history of learning problems? Y/N Please explain._____

_____

_____

At what grade did your child start to experience difficulty?_____

Is your child tutored currently?_____

Does your child have difficulty with:

____Phonics ____Spelling ____Reading Comprehension ____Oral Expression

____Mathematics Facts ____Mathematics Word Problems ____Writing

Is your child reading at grade level? Y/N

Please mark any of the areas that are of concern about your child. Use the back of this paper for additional comments.

Listening Behaviors:

1. Does not pay attention (listen) to instructions 50% or more of the time
2. Does not listen carefully to directions: often necessary to repeat instructions
3. Forgets what is said in a few minutes
4. Difficulty following directions
5. Often misunderstands what is being said
6. Say “huh?” and/or “what” at least five times a day
7. Cannot attend or listen to auditory stimuli for more than a few seconds
8. Short attention span (please mark most appropriate time frame)

   ___0-2 minutes __2-5 minutes __5-15 minutes ___15-30 minutes
9. Daydreams; attention drifts or not “with it” at times
10. Easily distracted by background noises

Speech and language:

11. Difficulty with phonics
12. Problems with Sound Discrimination
13. Trouble Reading/following a sequence (step-by-step instructions)
14. Does not remember simple routine things from day to day
15. Does not understand many words or concepts for age level
16. Slow or delayed responses to speech
17. Has a language problem (morphology, syntax, vocabulary, phonology, etc.)
18. Speech is not clear/articulation errors/difficulty with expressive speech
19. Cannot always easily relate to what is said with what is seen
20. Learns poorly if it is a “hearing only” task

Motivation/Attitude

21. Lacks motivation to learn
22. Low self-esteem

Academics

23. Difficulty with reading comprehension
24. Strong subjects_____

    Weak subjects_____

Overall Bevhavior

25. Behavior problems in class and/or at home
26. Has an “attitude” about school and learning

(((The Hearing Center)))

OFFICE POLICIES

1. All patients will be asked to produce a valid photo ID at the time of their appointment. If you have had an appointment within the last six months, this requirement will be waived. If not, the staff will verify your current information and if appropriate, require you to complete a new patient registration form.
2. All payments and CO-payments are due before services are rendered. We cannot bill you for co-payments. We accept check, cash, credit cards (Visa, Mastercard, Discover, Amex). The patient/guarantor is responsible for all payments regardless of insurance coverage.
3. If your health insurance requires a referral, it is your responsibility to obtain a referral from your primary care physician prior to your appointment. If you do not have a referral at the time of your appointment, you are responsible for payment as your insurance company may not pay for your visit without a referral.
4. Patients with outstanding account balances will be notified 10 days prior to submission to collection. Accounts that go into collection will be subject to a 35% collection charge. Accounts with balances that exceed 60 days will be subject to a late fee of $10.00, which will then be added to the account balance every 30 days thereafter.
5. There is a $35 charge for returned checks
6. It is your responsibility to notify our office of any name changes or changes in address, phone numbers, or insurance coverage. We need this information to bill your insurance company, and in the event that we have outdated information, any accumulated account balances will be your responsibility.
7. Patients under the age of 18 must be accompanied by an adult.

Patient Signature: _____

Guardian Signature: _____

Printed Name: _____

Privacy Practices Acknowledgement

Patient Name:_____

Please fill out the following information sign and date below.

The Hearing Center **may** leave private health information, on an answering machine or voice mail, regarding the above named patient.

Please list phone numbers where we may contact you or leave messages:

HOME:_____

WORK:_____

CELL:_____

EMAIL:_____

List people or family members with whom we may leave private health information.

_____relationship_____

_____relationship_____

_____relationship_____

I have been provided an opportunity to review the Notice of Privacy Practices.

Signed_____ Date_____