Syracuse Hearing Solutions
@ Preferred Audiology Care, LLC
5639 W. Genesee Street
Camillus, NY 13031
Phone: (315) 468-2985 | Fax: (315) 320-0245
www.syracusehearingsolutions.com

Auditory Processing Case History Form

Today's date:_____

Patient's name:_____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (H): _____ (C): _____

Insurance: _____ Referral Needed? ❑ Yes ❑ No

Please note that not all insurances will cover the cost of this testing. Please contact your insurance company for more information regarding coverage. We will bill your insurance for testing; however you will be responsible for your copay and any applicable non-covered portion.

Referred by: _____
Person completing form: _____
Relationship to patient: ❑ Parent/Guardian ❑ Self ❑ Other:_____

Results will be sent to names/locations listed below if address or fax number is provided.

Name	**Address or Fax**	**Phone**

I authorize Preferred Audiology Care, LLC to disclose the results of this evaluation to those listed above:

_____
Signature
Relationship to patient: ❑ Parent/Guardian ❑ Self
Printed Name:_____

Results will not be available on the day of the evaluation as all results must be analyzed. A report will be ready by 10-14 days after testing is complete. The report will explain findings and recommendations for school and home. Parents may contact the audiologist who completed the evaluation if they have any questions about the results.

Reason(s) for testing:
_____
_____

Medical history:
Do you have a history of ear infections? ❑ Yes ❑ No
If yes, how many? _____ When was the last ear infection?_____
Have you ever had PE tubes? ❑ Yes ❑ No
If yes, when? _____

Do you have a documented hearing loss? ❑ Yes ❑ No
If yes, please describe:_____
Family history of hearing loss? ❑ Yes ❑ No
Family history of APD? ❑ Yes ❑ No
Family history of learning disabilities? ❑ Yes ❑ No
Have you ever had a concussion or TBI? ❑ Yes ❑ No
Do you have a chronic illness or disease? ❑ Yes ❑ No
If yes, please explain: _____
_____

Please list all medications you are currently taking:
_____
_____
Please note any other pertinent medical information:
_____
_____

Have you ever been evaluated for APD before? ❑ Yes ❑ No
If yes, where?_____
Describe results:_____
_____
Have you ever been diagnosed with any of the following?

Learning disability* ❑ Yes ❑ No
Mental delays * ❑ Yes ❑ No
Speech/Language disorder* ❑ Yes ❑ No
ADD or AD/HD* ❑ Yes ❑ No
If yes, is medication prescribed? ❑ Yes ❑ No
Is medication currently being taken? ❑ Yes ❑ No
Results of medication: _____
Physician managing care: _____
Other diagnosis* ❑ Yes ❑ No

If you answered yes to any of the above, please describe:
_____
_____
*If you answered yes to any of the above, please include copies of professional evaluations/reports.

Educational/Occupational Information:
Are you (circle one): Right handed Left handed Mixed dominant
Occupation: _____
Highest level of education: _____
Did you have an IEP in school? ❑ Yes ❑ No
If so, what educational supports did you have?
_____
_____

Do you notice concerns with any of the following?

Please check the following:	Yes	No		Yes	No
Trouble understanding TV			Involved with drugs		

Sensitivity to loud sounds			confused in noisy places		
Trouble telling where sounds are			Often says “huh” or “what”		
Problems following directions			Mixes up sounds		
Difficulty with phonics			Difficulty with reading mechanics		
Difficulty with spelling			Difficulty with reading comprehension		
Difficulty pronouncing words/sounds			Small vocabulary compared to peers		
Easily distracted			Does not complete assignments		
Daydreams			Restless		
Forgetful			Problem sitting still		
Social difficulties			Rowdiness		
Disruptive			Needs quiet to study		
Preference for solitary activity			Headaches		
Lacks motivation			Short attention span		
Easily frustrated			Temper tantrums		
Tires easily			Easily frustrated or confused		
Often tense or anxious			Hyperactive		
Uncooperative			Disobedient		
Clumsy			Shy		
Impulsive			Irritable		
Lacks self-confidence			Destructive		
Easily upset by new situations					
Has a problem with time concept			Seeks attention		
Underachiever					

Occupational concerns: _____
_____
_____
_____