SYRACUSE HEARING Solutions

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.

****Results of Speech/Language testing and an Educational Psychology evaluation must be provided for review prior to completion of Auditory Processing testing.** **This is because we want to be able to view your child's skills as a whole to best meet their needs.**

Name:_____ **DOB:**_____

Reason(s) for testing (check all that apply):

❑ Academic concerns ❑ Reading/phonics problems
❑ Speech/language problems ❑ Attention problems
❑ Hearing concerns ❑ Other:_____

Home and Family Information:

Father's Name: _____ Age: _____
Occupation:_____
Mother's Name: _____ Age: ____
Occupation: _____
Child lives with:_____
Language(s) spoken at home: _____

Other children in the family:

Name	Age	Sex	Grade	Speech, hearing, learning or medical problems

Birth History:

Was your child: ❑ Full term ❑ Premature – If so, what was length of pregnancy? _____
Please list any pregnancy/birth complications:
_____
_____
_____
Was your child in the NICU for any period of time after birth? ❑ Yes ❑ No
If yes, how long was the stay?_____

Medical history:

Does your child have a history of ear infections? ❑ Yes ❑ No
If yes, how many? _____ When was the last ear infection?_____
Has your child ever had PE tubes? ❑ Yes ❑ No
If yes, when? _____
Does your child have a documented hearing loss? ❑ Yes ❑ No
If yes, please describe:_____
Have any immediate family members been diagnosed with an auditory processing disorder?
❑ Yes ❑ No If yes, who? _____
Did your child meet developmental milestones on schedule? ❑ Yes ❑ No
If no, please explain: _____
_____
Does your child have a chronic illness or disease? ❑ Yes ❑ No
If yes, please explain: _____
_____

Name:_____ **DOB:**_____

Please list all medications your child is currently taking:

_____

_____

Please note any other pertinent medical information:

_____

_____

Has your child ever been evaluated for APD before? ❑ Yes ❑ No
If yes, where?_____
Describe results:_____

_____

Has your child 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 Information:

Is your child (circle one): Right handed Left handed Mixed dominant
School attended: _____
School district: _____
Grade: _____
Number of children in class: _____
My child's academic performance is:
❑ Excellent ❑ Above average ❑ Average ❑ Below average ❑ Poor
Does your child like school? ❑ Yes ❑ No
Has your child ever repeated a grade? ❑ Yes ❑ No If yes, which grade and why?

_____

Does your child have an IEP or 504 Plan? ❑ Yes ❑ No If yes, what services does your child receive? _____
Does your child receive any support services other than those on an IEP/504 Plan?
❑ Yes ❑ No If yes, please explain: _____
Best school subject: _____
Weakest school subject: _____
Extracurricular activities: _____

Name:_____ **DOB:**_____

How would you rate your child's vocabulary?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Has your child ever received speech/language therapy? ❑ Yes ❑ No

If yes, please explain: _____

_____

Please check the following:	Yes	No		Yes	No
Trouble understanding TV			Involved with drugs		
Sensitivity to loud sounds			Appears 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			Preference to play with older children		
Daydreams			Restless		
Forgetful			Problem sitting still		
Preference to play with younger children			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			Excessive talking		
Has a problem with time concept			Seeks attention		
Fakes illnesses			Does not complete assignments		
Underachiever			Dislikes school		

Has your child's teacher ever expressed concerns with your child's progress? Please explain:

_____

_____

Please list any other educational concerns:

_____

_____