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AUDITORY PROCESSING ADULT CASE HISTORY

Client's Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: ____Female ____Male

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Family or Emergency Contact Name: _____

Relationship: _____Home Phone: _____

Referred by: _____

Reason for Referral: _____

_____

What questions are you hoping to answer during our initial appointment?

_____

_____

What are your main concerns: _____

_____

What would you like to be different following APD therapy?

_____

_____

I. **General Information**

Are you Right Handed _____ Left Handed _____ Mixed Dominant _____

Languages spoken at home: _____

First language: _____

Do you play an instrument? _____ Which instrument? _____ How many years? ____

Have you ever been evaluated for a Central Auditory Processing Disorder?

Yes ___ No ___

If yes, where?_____

What were the results? _____

_____

Do you have any of the following diagnoses?

Learning Disability*	Yes _____	No _____
Cognitive Delays*	Yes _____	No _____
Speech/Language Disorder*	Yes _____	No _____
ADD/ADHD*	Yes _____	No _____
Middle ear infections	Yes_____	No_____
Traumatic Brain Injury (TBI)*	Yes_____	No_____
Schizophrenia *	Yes_____	No_____
Other diagnosis*	Yes _____	No _____

If you answered yes, please provide additional detail: _____

_____

_____

***PLEASE PROVIDE COPIES OF PROFESSIONAL EVALUATIONS, IF APPLICABLE**

Were you adopted? Yes ____ No ____ If yes, at what age? _____

Other individuals living in your household: _____

Do you feel safe at home? Yes ____ No ____

Do you play a musical instrument?: _____

Does anyone in your family have a diagnosed auditory processing disorder? Yes ____ No ____ If yes, who? _____

II. **EDUCATIONAL INFORMATION**

Highest grade level completed: _____

Are you currently a student? Yes ____ No ____

If yes, where are you attending school: _____

What are you studying? _____ When do you expect to graduate? _____

Please list specific academic areas of concern:_____

Do you receive special education support as a student? Yes ____ No____ If yes, which services or accommodations?

_____

III. **HEARING HISTORY**

Do you have a diagnosed hearing loss? ___ No ___ Yes

If yes, who diagnosed the hearing loss?_____

What type of hearing loss? _____ Which ear(s)? _____

Do you wear hearing aids or cochlear implants? _____

Do you have concerns regarding your hearing? ___ Yes ___ No If yes, what are your concerns?

_____

Why do you think you may have an auditory processing disorder?

Is there anything else you would like us to know?

_____ _____

Print Name Relationship to patient

_____ _____

Signature Date