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AUDITORY PROCESSING CHILD CASE HISTORY

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

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

Address: _____

City: _____ State: _____ Zip: _____

Mother/Guardian's Name: _____

Home Phone: _____ Cell: _____ Other: _____

Email: _____

Father/Guardian's Name: _____

Home Phone: _____ Cell: _____ Other: _____

Email: _____

Referred by: _____

Reason for Referral: _____

_____

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

_____

_____

What are the main concerns you have regarding your child's listening, language, communication and academic performance: _____

_____

I. **General Information**

Child is Right Handed _____ Left Handed _____ Mixed Dominant _____

Languages spoken at home: _____

What is parents' primary language: _____

How old was child when he/she started speaking English: _____

Does child play an instrument? _____ Which instrument? _____ How many years? ____

Has your child ever been evaluated for a Central Auditory Processing Disorder?

Yes ___ No ___

If yes, where?_____

What were the results? _____

_____

Does your child 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**

II. **EDUCATIONAL INFORMATION**

Grade Level: _____ School: _____ District: _____

Teacher/Contact: _____ Number of students in class: ___

Classroom type: ___ Traditional ___Open Pod ___Self Contained

Has your child repeated a grade? ___No ___Yes If so, which grade? ____

Does your child have frequent absences? ___No ___Yes

Please list specific academic areas of concern:_____

Please list any other learning areas of concern: _____

Does your child receive special education services? ___No ___Yes If yes, which services?

_____

Is your child on a 504? ___No ___Yes What accommodations is your child receiving from the school? _____

Does your child receive services for speech? ___No ___Yes If yes, please explain_____

_____

III. **FAMILY HISTORY**

Mother's occupation _____ Age _____

Mother's address _____

Father's occupation _____ Age _____

Father's address _____

Is child adopted? ____No ____ Yes If yes, at what age? _____

Sister's Names: _____ Age _____Birth Child___ Adopted ___

Sister's Names: _____ Age _____Birth Child___ Adopted ___

Sister's Names: _____ Age _____Birth Child___ Adopted ___

Brother's Names: _____Age _____Birth Child ___Adopted ___

Brother's Names: _____Age _____Birth Child ___Adopted ___

Brother's Names: _____Age _____Birth Child ___Adopted ___

Other individuals living in the household: _____

Family's Marital History: _____

Does your child play a musical instrument?: _____

Please describe any history of hearing or learning problems of other family members: _____

_____

IV. **PREGNANCY AND DEVELOPMENT**

Length of pregnancy: _____ weeks

Birth Weight: _____ Small for Gestation Age ____ No ____ Yes

Low birth weight ____ No ____ Yes

Apgar scores normal? ____ No ____ Yes If not, what was the score?

Were there any complications during delivery?

Was medication taken during pregnancy? ____ No ____ Yes Which medications?_____

_____

Was bedrest required during pregnancy? ____ No ____ Yes For what reason? _____

V. **HEARING HISTORY**

Was your child's hearing screened at birth? ___ Yes ___ No What were the results? _____

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

Does your child have a diagnosed hearing loss? ___ No ___ Yes

If yes, who diagnosed the hearing loss?_____

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

Does your child wear hearing aids or a cochlear implant? _____

Is there anything else you would like us to know about your child?

_____ _____

Print Name

Relationship to patient

_____

Signature

_____

Date