Sedona Hearing Center
Sounds wonderful

PEDIATRIC CASE HISTORY FORM

Child's Name: _____
Last First Middle

Date of Birth: _____ Age: _____ Gender: Male □ Female □

Address: _____
Street City State Zip

Father: _____ DOB: _____ Education: _____

Address: _____ Phone (Home): _____ (Cell) _____

Occupation: _____ Place of employment: _____ Phone: _____

Mother: _____ DOB: _____ Education: _____

Address: _____ Phone (Home): _____ (Cell) _____

Occupation: _____ Place of employment: _____ Phone: _____

E-Mail: _____ Parents' Marital Status: S__ M__ D__W__ Insurance: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: _____

Person completing questionnaire: _____ Relationship to child: _____

REFERRAL INFORMATION

Referred by: _____

Reason you are bringing this child for the evaluation: _____

_____

Where did you hear about our services? _____

BIRTH AND PRENATAL HISTORY

Birth weight: _____ Premature? □ Yes □ No NICU stay? □ Yes □ No

Were there any complications during pregnancy or at birth? _____

_____

List drugs/medication taken during pregnancy: _____

At birth did the baby have the following: (please check)

Anoxia (blue color)	□ Yes □ No	Respiratory distress (breathing problems)	□Yes □No
Jaundice (yellow color)	□ Yes □ No	Remain in the hospital	□ Yes □ No, if "yes", how long? _____
Swallowing problems	□ Yes □ No	Sucking problems	□ Yes □ No

MEDICAL INFORMATION

Name of child's physician: _____ Date of last visit: _____

Reason for last visit: _____

Please list any medications that the child is currently taking: _____

_____

Check if the child has ever had the following:

- ☐ Ear infection ☐ Ventilation tubes in the eardrum ☐ Excessive ear wax ☐ Seizures
- ☐ Ear pain ☐ Ringing in ears ☐ Meningitis ☐ Dizziness
- ☐ Head injury ☐ Allergies ☐ Migraines ☐ Asthma ☐ High fever
- ☐ Major medical problems (i.e., heart, lung, physical disabilities) Please explain:_____

_____

Overnight stays and/or surgeries? ☐ Yes ☐ No. If "yes", list date and reason: _____

_____

DEVELOPMENTAL HISTORY

At what age did child do the following? ____ Sit alone ____ Crawl ____ Walk ____ Become toilet trained

Do you have any concerns with your child's development? ☐ Yes ☐ No. If "yes", explain _____

_____

SPEECH AND LANGUAGE DEVELOPMENT

Which languages are spoken at home? _____ What is the child's primary language? _____

At what age did child do the following?
____ Babble ____ Imitate sounds ____ Say first word ____ Use 2 to 3 word phrases ____ Make complete sentences _____

About how many words are in your child's vocabulary? ____

Can you understand your child's speech? ☐ Yes ☐ No Can other people understand your child's speech? ☐Yes ☐No

Does your child follow commands and directions? ☐ Yes ☐ No. If "No", explain _____

_____

Are you concerned about your child's speech and language development? ☐ Yes ☐ No. If "yes", explain _____

_____

HEARING HISTORY

Did child pass the newborn hearing screening? ☐ Yes ☐ No. If "no", explain _____

Check all that apply:

- ☐ The child has trouble hearing
- ☐ The child needs to hear instructions several times
- ☐ It helps the child when people speak loudly
- ☐ TV/radio is excessively loud
- ☐ There are sounds that make child uncomfortable
- ☐ The child "tunes in and out" of listening situations
- ☐ My child's teacher/daycare worker has mentioned my child having trouble hearing in school.

Are you concerned about your child's hearing? ☐ Yes ☐ No. If "yes", explain _____

_____

Does anyone in the child's family have hearing loss beginning before age 30? ☐ Yes ☐ No. If "yes", explain _____

_____

SCHOOL INFORMATION (check all that apply)

What school does your child attend? _____ Grade _____ Teacher _____
Is your child having any academic trouble in school? □ Yes □ No. If "yes", explain _____

_____

Does the child receive any special services at school/daycare or privately (i.e., speech therapy, physical therapy, occupational therapy, learning disables class, bilingual services, etc.)? □ Yes □ No. If "yes", please explain _____

_____

Does the child receive any special services privately (i.e., psychological, psychiatric, neurological, speech, hearing, visual, educational, medical, and other? □ Yes □ No. If "yes", please explain _____

_____

ADDITIONAL NOTES/COMMENTS

_____

_____

_____

_____

Although every effort is made to obtain accurate benefits information, your insurance company does not guarantee payment. By signing this document, you (the patient or responsible party) agree to be fully and personally responsible for any unpaid balances. A 1.5% (18% per annum) interest charge may be assessed to delinquent accounts. Your signature also indicates that you have read the information on this sheet and allows our office to release your medical records to insurance companies, physicians or other medical personnel involved with your care. It will serve as a "Signature on File" for insurance claims and must be updated on an annual basis.

_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Signature of Parent/Legal Guardian **Date**

SHC 3/2016