



CENTRAL AUDITORY PROCESSING ASSESSMENT – CASE HISTORY

Today's Date: _____

Child's Name: _____

Referred by/clinic: _____

Reason for Referral: _____

EDUCATIONAL HISTORY

School: _____ Grade: _____

Place a check mark next to any educational problem(s) that your child currently has:

Difficulty with reading _____ Difficulty with math _____
Difficulty with spelling _____ Difficulty with writing _____ other _____

If other, please explain: _____

When the difficulties were first noted: _____

Is your child in a special education class: Yes _____ No _____

If yes, what type of class?: _____

Has your child ever received remedial help (tutoring, extra help at school): Yes _____ No _____

If yes, in what area(s): _____

Where: _____ How often: _____

Starting Date: _____



PREVIOUS ASSESSMENTS

Type of Assessment:	Date:	Place:	Findings:
Psycho Educational	_____	_____	_____
Speech and Language	_____	_____	_____
Hearing	_____	_____	_____
Vision	_____	_____	_____
Other	_____	_____	_____

Please check the following behaviors that may be pertinent to your child.
For questions that provide multiple choices, circle the options that apply to the child.

MEDICAL HISTORY

____ 1. History of hearing loss?

____ 2. History of ear infection(s)
None _____ Very few _____ Several _____ Many _____

Date of last ear infection(s): _____

____ 3. History of PE tubes. If yes, when? _____

____ 4. Complications before, during or after birth? (e.g. low birth weight, hypoxia, head trauma, high fever, Rh incompatibility, jaundice, viral infection, antibiotics, was the child in the NICU)

____ 5. History of allergies, asthma, reactive airway disease, frequent colds, and upper respiratory infections.

____ 6. History of hypo/hyperactivity.

____ 7. History of Attention Deficit Hyperactivity Disorder (ADHD). If so:
a) What age was your child diagnosed: _____
b) Diagnosed by _____ Profession: _____
c) Is your child receiving medication for ADHD: _____
d) How long does it take to see the medication's effect: _____
e) Is your child receiving
counseling: _____
tutoring: _____
behavioral intervention: _____

____ 8. Has your child ever been diagnosed with a learning disorder? If yes, explain:



DEVELOPMENTAL HISTORY

Was your child's speech and language development normal? Yes _____ No _____

If no, explain: _____

Was there any other developmental milestones (e.g. walking, fine/gross motor) delayed?

Yes _____ No _____ If yes, explain: _____

FAMILY HISTORY

Have there been any other family members diagnosed with:

Hearing loss (not age related)	Yes / No
Learning Difficulty / Disability	Yes / No
Central Auditory Processing difficulties	Yes / No
ADHD (Attention Deficit Hyperactivity Disorder)	Yes / No

LISTENING DIFFICULTIES AND AUDITORY COMPLAINTS

- _____ 1. Says "huh" or "what" frequently.
- _____ 2. At times, appears to have a hearing loss.
- _____ 3. Frequently asks for directions or instructions to be repeated.
- _____ 4. Difficulty hearing in noise or comprehending verbal message in noise.
- _____ 5. Difficulty hearing speakers with poor enunciation or with a foreign accent.
- _____ 6. Frequent "mishearing" and subsequent misunderstanding..
- _____ 7. Responds in a slow or delayed manner when spoken to.
- _____ 8. Responds too quickly to situations without waiting for instructions.
- _____ 9. Daydreams, attention drifts and/or short attention span.
- _____ 10. Difficulty comprehending the "intent" (rather than context) of communications
- _____ 11. Difficulty perceiving jokes, sarcasm and language subtleties.
- _____ 12. Feels as if his/her right ear is better or prefers using his/her right ear.
- _____ 13. Exhibits a low or abnormal tolerance for noise (e.g., sensitive to loud sounds).
- _____ 14. Easily distracted in noisy situations.
- _____ 15. Communication is enhanced when visual information is provided.
- _____ 16. Displays difficulty when provided with lengthy and/or complex information.
- _____ 17. Often "hears" a similar word (e.g., bath vs. math, shoe vs. zoo)
- _____ 18. Learns poorly through the auditory channel.
- _____ 19. Shows difficulty in differentiating musical instruments or notes.

ACADEMIC DIFFICULTIES AND EDUCATIONAL COMPLAINTS

- _____ 1. Displays inconsistency in school performance.
- _____ 2. Rushes through homework without realizing that errors were made.
- _____ 3. Does homework takes longer time when compared to amount of work?
- _____ 4. Not motivated to learn new concepts.
- _____ 5. Tests reveal better performance results than verbal results.
- _____ 6. Performs well in a one-on-one situation.
- _____ 7. Is disruptive in class.
- _____ 8. Interrupts peers or teachers.
- _____ 9. Performance improves in a structured environment.
- _____ 10. Displays weak reading/writing/spelling skills (e.g., difficulty with phonics).
- _____ 11. Has difficulty explaining a story or idea.
- _____ 12. Does not complete tasks or is not organized with tasks.
- _____ 13. Appears unusually fatigued towards the end of the school day.
- _____ 14. Problems learning foreign languages.



AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)		Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)		
Phone Number	E-mail	

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize that any health care professional may receive the following health information that relates to service performed by Audiology Associates of South Florida may be released:

- Entire Medical Record including patient histories, office notes, test results, and consults.
- Patient Histories
- Office Notes
- Test Results
- Consults

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Print Name of person signing this form:
		Relation to the patient:



Electronic Communication Agreement (eCommunications)

Health Notifications

You allow Audiology Associates of South Florida to send you test results and health reminders via email.

Email ☐ Valid email address: _____

Appointment Reminders

You allow Audiology Associates of South Florida to contact you to remind you about scheduled appointments.

Email ☐ Phone ☐ Text ☐

Updates and Announcements

You allow Audiology Associates of South Florida to notify you regarding appointment cancellations, appointment reschedules and other important announcements.

Email ☐ Text ☐

Billing

You allow Audiology Associates of South Florida to send you electronic statements. You can view your billing statements and pay outstanding balances on our secure Payment Portal by Payjunction. If necessary, we will notify you if a balance is past due.

Email ☐ Text ☐

By checking the box below, you consent and agree to receive electronic notices and disclosures as described in the [eCommunications Disclosure Agreement](#).

(Request copy from front desk)

- ☐ Go Paperless - Receive your statements online and other notices electronically
(Please ensure you have provided a valid email address on page 1 or on line provided above)

Signature: _____ Date: _____
Signature of Patient/Parent/Guardian