REM Audiology Associates P.C.

AUDITORY PROCESSING CASE HISTORY

Patient Name: Date:

Your Name & Relationship to child: ____

Date of Birth: __________ Age: ______ Gender: ___M ___F

Child lives with: ____both parents ____mother ____father ____other

Name and ages of other children in home: ___________________________________

Referral Source: ________________________

Name of Child's School, Preschool, or Child Care Setting: ____________________________________

Grade: _______ Number of Children in Class (approx): _______

Current Educational Setting: Traditional Inclusion Special Education Home School

HEARING HISTORY	**YES**	**NO**
Do you have any concerns about your child's hearing?	☐	☐
Does anyone in your family have hearing loss that began before age 30? (immediate and extended family)	☐	☐
Has your child ever had tubes?	☐	☐
Does your child consistently respond to your voice?	☐	☐
Does your child respond to loud noises?	☐	☐
When sound is present or someone is speaking, does your child search to find the sound?	☐	☐
Does your child have a problem listening or understanding?	☐	☐
Has your child's hearing ever been tested?	☐	☐

When/Where?________________ Results?________________________

Does your child wear hearing aids?	☐	☐
If yes, when was your child fit? _______________		
Does your child use an FM system/auditory trainer?	☐	☐

PREGNANCY AND BIRTH HISTORY	**YES**	**NO**
Were there any complications during pregnancy?	☐	☐
Were there any complications during delivery?	☐	☐
Was the child born full term?	☐	☐

	YES	NO
Did the mother have any illnesses during pregnancy?	☐	☐
Did the mother take any medication during pregnancy?	☐	☐
After birth, did your child have...		
Extra hospitalizations?	☐	☐
Breathing difficulties?	☐	☐
Require an incubator?	☐	☐
Any head, neck, or ear abnormalities?	☐	☐
Feeding problems?	☐	☐
Surgery?	☐	☐
Any infections requiring medication?	☐	☐
Treatment for jaundice (yellow coloration of the skin)?	☐	☐
If yes to any of the above, briefly explain:__________________		
Did your child pass the Newborn Hearing Screening?	☐	☐

MEDICAL HISTORY

	YES	NO
Do you have any medical concerns about your child?	☐	☐
If yes, briefly explain: __________________________		
Does your child your child have a diagnosis of any of the following? Learning Disability	☐	☐
Mental Delays	☐	☐
Speech/Language Disorder	☐	☐
ADD/ADHD	☐	☐
If you checked "yes" to ADD/ADHD:		
Has medication been prescribed for your child?	☐	☐
When was your child diagnosed? _________________		
What medication is your child taking?_______________		
What dosage is your child taking?_________________		

Please check if your child has had any of the following:

Vision Problems	Seizures	Ear Surgery	Ear infections (how many?)____
Measles	Allergies	Asthma___	Frequent colds/infections
Meningitis	Kidney problems	Hospitalization	Mumps
Head trauma/injury	Noise Exposure (e.g. loud music, guns, etc.)		

Other significant medical concerns:________________________________

Please list any prescription or over-the-counter medications your child is taking:

____

PHYSICAL DEVELOPMENTAL HISTORY

	YES	NO
Do you have any concerns about your child's physical development?	☐	☐

If Yes, briefly explain:

Approximately what age did your child:
- hold head erect ____________
- sit unsupported __________
- crawl__________________
- walk alone________________

	YES	NO
Does your child lose his/her balance or fall easily?	☐	☐
Does your child seem uncoordinated or clumsy?	☐	☐

SPEECH & LANGUAGE HISTORY

	YES	NO
Do you have any concerns about your child's speech and language?	☐	☐

If yes, briefly explain: ________________________ __

	YES	NO
Has your child's speech ever been evaluated?	☐	☐

When/Where?_____________ By whom?_________

	YES	NO
Is your child currently receiving speech therapy?	☐	☐

Where?__________________ By whom?_________

About what age did your child:
- follow simple directions ____________
- say a first word ____________
- put two words together ___________

	YES	NO
Does your child often use gestures to communicate?	☐	☐
Is your child's speech understood by: Parents?	☐	☐
Siblings?	☐	☐
Other adults?	☐	☐

EDUCATIONAL HISTORY

School performance is:

Excellent Above Average Average

Below Average Poor

	YES	NO
Is there a family history of learning problems?	☐	☐

If yes, briefly explain:__________________________

Child's preferred hand: Right ___Left

Does your child have an: IEP 504 Plan Classroom Modifications

What modifications does your child receive?

____

____

____

	YES	NO
Does your child have any difficulty with any subjects in school?	☐	☐

If yes, which one(s)____

In what grade level did your child begin to experience difficulty? ____________

What is your child's best subject(s) in school?____________________________

Does your child participate in any special class(es) or therapies? ☐ ☐

If yes, explain:__________________________

Has your child ever been tutored? ☐ ☐

Has your child ever repeated a grade? ☐ ☐

Does your child have difficulty with:

- Phonics ☐ ☐
- Spelling ☐ ☐
- Reading Mechanics ☐ ☐
- Reading Comprehension ☐ ☐

Is your child reading at grade level? ☐ ☐

If no, what level is your child reading on? ________

How would you rate your child's vocabulary?

Excellent Good Fair Poor

Has your child had any of the following evaluations?

If yes, please indicate when the evaluation was done and the outcome of the evaluation

Speech/Language

Psychoeducational

Attention/Behavioral

Other:

Please indicate if your child exhibits any of the following behaviors or characteristics:

__sensitive to loud sounds
__appears to be confused in noisy places
__easily upset by new situations
__difficulty following and/or understanding TV programs
__difficulty following directions
__does opposite of what is requested
__restless; problems sitting still
__overly active
__short attention span
__impulsive
__easily distracted
__lacks self confidence
__lacks motivation

__uncooperative
__disobedient
__destructive
__inappropriate social behavior
__does not complete assignments
__easily frustrated
__tires easily
__irritable
__dislikes school
__fakes illnesses
__awkward/clumsy
__forgetful
__asks for repetition
__reverses words, numbers or letters

__prefers to play with older children
__prefers to play with younger children
__prefers solitary activities
__disruptive or rowdy
__temper tantrums
__shy
__poor speller
__difficulty with expressive writing
__poor handwriting
__confuses similar sounding words/letters
__difficulty verbally expressing thoughts/ideas
__difficulty remembering assignments/ completing work

Please indicate any further comments or concerns: ____

Besides yourself, who should receive copies of the evaluation report? Please provide addresses or email addresses