Auditory Processing Case History

Person Completing this form:____________________________________ Date________________

Relationship to patient: ____

Identification Information

Name: ____ DOB: _______________________

Mother's Name: _________________________Father's Name: ________________________

Primary Address: ____

City: ____________________________ State: __________ Zip Code: ________________

Telephone: (H) ________________ (C) _________________ (W) ____________________

Referred By: ____________________________ Phone: ______________________________

Pediatrician: ___________________________ Phone: ______________________________

School: ____________________________________ Current Grade Level: _____________

Preferred Hand: Right Left

Present Concerns and/or Behaviors

Please check all that apply to your child:

____ Ignores sound

____ Does not localize to sound

____ Difficulty with oral directions

____ Difficulty with written directions

____ Frequently needs things repeated

____ Comprehends single word directions

____ Problems when speaker turns away

____ Daydreams frequently

____ Is sensitive to loud sounds

____ Frequently mishears what is said

____ Restless

____ Overly active

____ Short attention span

____ Impulsive

____ Easily distracted

____Extremely forgetful

____ Difficulty grasping "sight words"

____ Problems with intonation patterns

____ Problems with complex instructions

____ Fluency problems

____ Prefers solitary activities

____ Is easily upset with new situations

____ Extremely shy

____ Tires easily

____ Difficulty working independently

____ Reverses numbers, letters or words

____ Difficulty with Phonics

____ Difficulty with Reading Comprehension or Reading Accuracy

____ Is confused in noisy situations

____ Difficulty with organization

____ Dislikes school

____ Shows abnormal anxiety

____ Frequently asks for repetition

____ Difficulty with new concepts

____ Temper tantrums

What specific problems does your child experience:

____

____

When was the problem first noticed: ____

Who first reported the problem: ____

Hearing/Speech-Language History

Was his/her hearing tested at birth: YES NO Results:__________________

Has he/she had a hearing test since birth: YES NO Results: __________________

Has he/she ever used amplification: YES NO

Has he/she ever had a speech-language evaluation: YES NO

Where/When/With What Clinician: ____

Has he/she ever had speech therapy YES NO

Dates/Locations/Clinicians:

____

____

____

Does he/she make articulation errors: YES NO

Is English the primary language at home: YES NO

If no, what language is primary: ____

Is there a family history of language problems: YES NO

If yes, explain: ____

Do you suspect any hearing problems: YES NO

Does he/she currently use a listening aid at school: YES NO

Developmental/Medical History

Relationship to child: Biological Adopted Foster Child

Length of Pregnancy: _________________weeks Type of delivery: _______________________

Any use of forceps or vacuum: ______________________ Bruising on head: ________________

Birth weight: _______________ Jaundice requiring light therapy: YES NO

Any health issues within the first 2 weeks of life including NICU, ventilation, feeding problems,…
____

____

Has he/she ever had any serious illnesses or accidents: YES NO

If yes, explain: ____

Has he/she ever had head trauma requiring CTscan or MRI: YES NO

If yes, explain: ____

Were there any documented developmental delays: YES NO

If yes, explain: ____

Does he/she have a history of ear infections: YES NO

Does he/she have a history of PE Tubes: YES NO

When/Physician:____

Is he/she currently on any medication or in the care of any physician for any medical condition including ADD or ADHD:

YES NO

If yes, list condition, physician, date of initial diagnosis, and any medications currently prescribed:
____

____

____

Educational History

How would you describe your child's performance in school:

Below Average Average Above Average Exceptional

Has your child had to repeat a grade level: YES NO If yes, which level:______________________

Best Subject: __________________________ Worst Subject: __________________________

Has your child undergone intelligence or psychoeducational testing: YES NO

If yes, where: _______________________ When: ________________________________

Results: ____

Has your child undergone neurological testing: YES NO

If yes, where: _______________________ When: ________________________________

Results: ____