Medical Record #: _____

Hackensack Meridian *Health*
Joseph M. Sanzari Children's Hospital

Audiology Department
(551) 996-5327

AUDITORY PROCESSING QUESTIONNAIRE

PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____ Date(s) of Evaluation: _____

_____ _____
Signature of Patient/Parent/Guardian *Relationship to Patient*

PREFERRED PROVIDER INFORMATION

Check box if you would like us to send results to your provider

Primary Care Physician/Pediatrician: Address: City/State/Zip: Phone Number: Fax Number:	☐
ENT/Otolaryngologist: Address: City/State/Zip: Phone Number: Fax Number:	☐
Hearing Aid Dispenser: Address: City/State/Zip: Phone Number: Fax Number:	☐
Other: Address: City/State/Zip: Phone Number: Fax Number:	☐

Patient Name: _____

Medical Record #: _____

Name of Person Completing Form: _____ Relationship to Patient: _____

PATIENT INFORMATION

Child's First, Middle, Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Primary Language: _____ Other Languages: _____

Primary concern for this appointment: _____

_____

Who referred your child for this appointment? _____

Current diagnosis of child (list all): _____

_____

Please check off previous evaluations your child has had; include month and year of last evaluation:

□ Learning Evaluation: _____ □ Developmental Pediatric Study: _____

□ Speech/Language Evaluation: _____ □ Psychological Evaluation: _____

□ Other: _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian (A) Full Name: _____
First *Last* *(Maiden)*

Date of Birth: _____ Race: _____ Ethnicity: _____

Please Check: Biological [ ] Step [ ] Foster [ ] Adoptive [ ] Other [ ] _____

Primary Language: _____

Phone Number: _____ Email: _____

Address: _____ City/State: _____ Zip: _____

☐ *check here if address is same as patient*

Parent/Guardian (B) Full Name: _____
First *Last* *(Maiden)*

Date of Birth: _____ Race: _____ Ethnicity: _____

Please Check: Biological [ ] Step [ ] Foster [ ] Adoptive [ ] Other [ ] _____

Primary Language: _____

Phone Number: _____ Email: _____

Address: _____ City/State: _____ Zip: _____

☐ *check here if address is same as patient*

PREGNANCY, BIRTH, & HEALTH HISTORY

Child's Place of Birth: _____ Birth Weight: _____

Was your child born prematurely? NO YES If yes, how many weeks? _____

Were there any complications during pregnancy or birth? _____

Was your child cared for in the NICU/special care nursery? Why? _____

Was a Newborn Hearing Screening completed at birth? _____ Results: _____

Does your child have any allergies? Please list: _____

_____

Is your child taking any medications? Please list: _____

_____

AUDIOLOGICAL HISTORY

Do you think your child has a hearing problem? _____

_____

Has your child ever had a hearing screening at the pediatrician's office? _____ Results? _____

Has your child ever had a complete hearing test before? NO YES

Date/Location: _____

Is there a history of middle ear infections/middle ear fluid? _____

When was the last ear infection? _____

Who has treated your child's ear infections? How? _____

Has your child ever had PE tubes? NO YES When: _____

Is there a family history of childhood hearing loss? Please explain: _____

DEVELOPMENT HISTORY

Do you have concerns regarding…

… your child's speech and language? NO YES: _____

… your child's development? NO YES: _____

… your child's behavior? NO YES: _____

… your child's general health/nutrition? NO YES: _____

Did your child ever receive any services through Early Intervention at home? NO YES

… if yes, what services? _____

Is your child right- or left-handed? _____ When did you first notice? _____

Have there been any *recent* changes in your child's behavior/mood? _____

HOME ENVIRONMENT

Have there been any recent major family problems such as death, illness, separation, or accident?

_____

_____

Describe family tensions (if any): _____

_____

_____

Primary language spoken at home: _____

ACADEMIC HISTORY

Current Grade Level: _____ Current School: _____

Do you have any concerns about your child's academics? If yes, explain: _____

_____

Do you think your child has a problem listening or understanding? Please explain: _____

_____

Has your child ever repeated a grade? If yes, which grade? _____

Does your child receive any special accommodations/therapy at school? NO YES

… If yes, what services? _____

Does your child have an Individualized Education Plan (IEP) or 504 plan? IEP 504 n/a

… What is the classification for services? _____

Does your child receive any private therapies/tutoring at home? NO YES: _____

Are you satisfied with your child's academic program? _____

_____

What are your child's academic *strengths?*

_____

_____

_____

What are your child's academic *weaknesses?*

_____

_____

_____

BEHAVIORS & CHARACTERISTICS *(check all that apply)*

- □ awkward, clumsy, poor coordination
- □ does opposite of what is requested
- □ reverses words, numbers, letters
- □ difficulty understanding sarcasm, humor, or figures of speech
- □ lacks musical ability
- □ restless; problems sitting still
- □ short attention span
- □ easily distracted
- □ daydreams
- □ overly active
- □ prefers to play with older children
- □ prefers to play with younger children
- □ prefers solitary activities
- □ difficulty making friends
- □ inappropriate social behavior
- □ easily upset by new situations
- □ impulsive
- □ sensitive to loud sounds
- □ appears to be confused in noisy places
- □ difficulty following directions
- □ asks for repetition
- □ forgetful
- □ seeks attention
- □ disruptive or rowdy
- □ temper tantrums
- □ shy
- □ anxiety
- □ lacks self-confidence
- □ lacks motivation
- □ uncooperative
- □ disobedient
- □ destructive
- □ does not complete assignments
- □ easily frustrated
- □ tires easily
- □ irritable
- □ dislikes school
- □ fakes illnesses
- □ difficulty verbally expressing him/herself

Additional Concerns/Comments: _____

_____

_____

_____

_____