Medical Record #: _____

HACKENSACK UNIVERSITY MEDICAL CENTER
AUDIOLOGY DEPARTMENT
Auditory Processing Evaluation History Questionnaire

We appreciate your cooperation in completing this questionnaire as fully as possible. The information will be useful in evaluating your child and addressing your concerns.

Date _____

Name of person completing form _____

Relationship to child _____

Who referred you to us for an evaluation? _____

Name of child's pediatrician _____

Current diagnosis of child: _____

What concerns do you have about your child? _____

_____

_____

When was it first noticed? _____

What have you been told about this/these problem(s)? _____

_____

_____

How do you think that we might be able to help you? _____

_____

_____

GENERAL INFORMATION

Child's Name _____ Birth Date _____ Sex: M F

Home Address: Street _____ Apt._____

County _____ City _____ State _____ Zip _____

Father _____ Birth Date _____

Occupation _____

Ethnic Background _____ Religion _____

Health _____ Years of Schooling _____

Mother _____ Birth Date _____

Occupation _____

Ethnic Background _____ Religion _____

Health _____ Years of Schooling _____

PREGNANCY HISTORY

Patient Name: _____

MR #: _____

Complications during pregnancy? _____

Explain: _____

Medications used during pregnancy? _____ How often? _____

Alcohol/Drug use during pregnancy? _____ How often? _____

BIRTH HISTORY

Child's place of birth: _____

Child's birthweight:_____ Plurality: _____ Prematurity: _____

How many weeks early or late? _____

Did your child require intensive care nursery after birth? _____ HowlLong? _____

Reason: _____

Newborn hearing screening performed at birth? _____ Results: _____

AUDIOLOGICAL HISTORY

Is there family history of childhood hearing loss? _____

Explain: _____

Do you think your child has a hearing problem? _____

Explain: _____

Has your child ever had a hearing test? _____When? _____

Where? _____ Results: _____

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

How often? _____

Who has treated your child's ear infections? _____

How have the ear infections been treated? _____

Does your child respond to his or her name? _____

Does your child respond to verbal directions consistently? _____

CHILD'S HEALTH & DEVELOPMENT

Do you have concerns regarding child's speech and language? _____

Do you have concerns regarding your child's development? _____

Do you have concerns regarding your child's behavior? _____

Do you have concerns regarding your child's general health/nutrition? _____

Does your child have any allergies? _____ please list: _____

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

Is your child left or right hand? _____When did you first notice a preference? _____

Is your child bilingual? _____ What languages? _____

Which language is your child more proficient? _____

Patient Name: _____

MR #: _____

LISTENING AND UNDERSTANDING

1. Do you think your child has a problem listening or understanding? YES NO If *yes*, give examples. How long have you been aware of this problem?	
2. Does your child have difficulty with any subjects at school? YES NO If *yes*, please list.	
3. What are your child's best subjects in school?	
4. Does your child participate in any special class(es) or therapies? YES NO If *yes*, describe.	
5. Has your child been tutored? YES NO If *yes*, please describe.	

BEHAVIORS AND CHARACTERISTICS

Indicate (√) if your child exhibits any of the following behaviors or characteristics.

- 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
- forgetful
- prefers to play with older children
- overly active
- impulsive
- daydreams
- prefers to play with younger children
- difficulty making friendships
- sensitive to loud sounds
- easily upset by new situations
- difficulty following directions
- appears to be confused in noisy places
- asks for repetition
- prefers solitary activities
- seeks attention
- disruptive or rowdy
- temper tantrums
- shy
- anxiety
- lacks self-confidence
- lacks motivation
- uncooperative
- disobedient
- destructive
- inappropriate social behavior
- does not complete assignments
- easily frustrated
- tires easily
- irritable
- dislikes school
- fakes illnesses
- difficulty verbally expressing him/herself

ACADEMICS

What school does your child attend? (Include early intervention programs, preschools, nurseries)

Patient Name: _____

MR #: _____

Name/Location	Grade/Class	Special Services (e.g., therapies)

Any school problems? _____

May we contact your child's teacher? YES NO If yes, please list information on release form.

Has your child ever been "classified" for special education? YES NO

Please explain _____

Has your child ever been held back in school? YES NO

Please explain _____

Has your child ever had private evaluations, tutoring, therapy? YES NO

Please explain _____

What are your child's academic *Strengths*? What are your child's academic *Weaknesses*?

_____ _____

_____ _____

Are you satisfied with your child's program? YES NO

Please explain _____

ENVIRONMENT

Any recent major family problems such as death, illness, separation, or accident? _____

Describe family tensions _____

Primary language spoken at home _____

ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

_____