

Auditory Processing Case History

Person completing this form: _____ Date: _____

Relationship to patient: _____

IDENTIFICATION

Name: _____ DOB: _____

Mother's name: _____ Father's Name _____

Address: _____

Telephone: (H) _____ (W) _____

Referred by: _____

Name of Child's physician: _____

Address & Phone: _____

School: _____ Grade _____

Child's preferred hand: right _____ left _____

PRESENT CONCERNS/BEHAVIORS

Please indicate (X) all that apply to your child:

- | | |
|--|---|
| <input type="checkbox"/> Ignores sound | <input type="checkbox"/> Is sensitive to loud sounds |
| <input type="checkbox"/> Does not localize to sound | <input type="checkbox"/> Frequent 'mishearing' of what is said |
| <input type="checkbox"/> Has trouble following oral directions | <input type="checkbox"/> Does the opposite of what is requested |
| <input type="checkbox"/> Has trouble following written | <input type="checkbox"/> Restless, problems sitting still |
| <input type="checkbox"/> Needs things repeated | <input type="checkbox"/> Overly active |
| <input type="checkbox"/> Can comprehend words in isolation | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> but has trouble when used in connected speech | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Has difficulty comprehending when a | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> speaker turns away | |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Forgetful (including forgetting daily |
| | <input type="checkbox"/> routines, losing items, etc) |
| <input type="checkbox"/> Has difficulty understanding intonation | <input type="checkbox"/> Difficulty with sound blending tasks |
| <input type="checkbox"/> Patterns | <input type="checkbox"/> Difficulty grasping sight words |

- | | |
|--|---|
| <input type="checkbox"/> Has fluency problems | <input type="checkbox"/> Appears confused in noisy places |
| <input type="checkbox"/> prefers solitary activities | <input type="checkbox"/> Difficulty with organization |
| <input type="checkbox"/> Easily upset by new situations | <input type="checkbox"/> temper tantrums |
| <input type="checkbox"/> shy | <input type="checkbox"/> anxious |
| <input type="checkbox"/> tires easily | <input type="checkbox"/> Dislikes school |
| <input type="checkbox"/> Difficulty working independently | <input type="checkbox"/> asks for repetition |
| <input type="checkbox"/> reverses words, numbers or letters | <input type="checkbox"/> difficulty understanding the meaning of
Words |
| <input type="checkbox"/> Difficulty learning new concepts | <input type="checkbox"/> Difficulty understanding the meanings of
Jokes or expressions |
| <input type="checkbox"/> Difficulty with phonics | <input type="checkbox"/> Difficulty with reading accuracy |
| <input type="checkbox"/> Difficulty with reading comprehension | |

What kind of problems is your child having? _____

When was the problem first noticed? _____

Who first noticed the problem? _____

Is there anything else about your child's behavior that concerns you? _____

HEARING/SPEECH/LANGUAGE HISTORY

Did your child receive a hearing screening at birth? YES NO

What were the results? _____

Has your child had a hearing test since birth? YES NO

Where? When? _____

If hearing loss was identified, please describe. _____

Has your child ever used amplification? YES NO

Has your child ever had a speech language evaluation? YES NO

Where? When? _____

Has your child ever had speech or language therapy? YES NO

If so, where? Dates? _____

Can your child spell words the way they sound? YES NO

Does your child have articulation errors? YES NO
 If so, what sounds are in error? _____
 What language is spoken at home? _____
 Is there a family history of language or learning problems? YES NO
 If yes, explain. _____
 Do you think your child hears adequately? _____
 Do you think that your child's hearing changes from day to day? _____
 Does your child use an auditory training device at school? _____

DEVELOPMENTAL/MEDICAL HISTORY

This child is our ___ biological ___ adopted ___ foster child
 What was the length of pregnancy? _____
 What type of delivery? ___ vertex (head presentation) ___ breech ___ caesarian
 Were forceps used? _____ Bruises? _____
 Birth weight? _____
 Were there any health problems during the first two weeks of the infant's life? If so, describe. _____
 Was the child jaundiced, requiring light therapy? _____
 Has your child had any serious illnesses or accidents? YES NO
 If yes, explain _____
 Has your child ever had heard trauma/CT scan/MRI? YES NO
 If yes, explain. _____
 Were there any delays in your child's development? YES NO
 If yes, explain _____
 Is the child presently taking any medication? YES NO
 If so, why? _____
 Name of medication _____
 Does the child have a history of ear infections? YES NO
 History of P.E. tube insertions YES NO
 When? _____

SOCIAL/BEHAVIORAL HISTORY

How does your child get along with other children? _____

Is child difficult to discipline? _____ Explain: _____

Would you describe your child as happy or unhappy? _____

Is child **unusually** quiet _____ **unusually** active? _____

Does your child play a musical instrument? _____ Which one? _____

Can your child ride a bike? _____ Play a sport (which one)? _____

EDUCATIONAL HISTORY/ASSOCIATED SERVICES

Describe your child's general performance in school. _____

Has your child repeated any grades? _____ Which one(s)? _____

Is your child frequently absent from school? _____

Best school subject? _____ Worst school subject? _____

How is your child's performance in math calculations vs. math word problems? _____

Has your child undergone intelligence testing? YES NO

Date: _____ Where? _____

Results: _____

Has your child undergone neurological testing? YES NO

Date: _____ Where? _____

Results: _____

Occupational/Physical therapy and/or Evaluation? YES NO

Date: _____ Where? _____

Results: _____