STONY BROOK UNIVERSITY MEDICAL CENTER

AUDITORY PROCESSING CASE HISTORY FORM

You must bring a PRESCRIPTION from your child's DOCTOR on the day of your appointment or we will not be able to perform the test.
If you are being referred by a school district, you must consult with your MD and request a prescription.

CHILD'S NAME: _____ DOB: _____

PERSON COMPLETING FORM: _____ RELATIONSHIP TO PATIENT:_____

PHONE (H): _____ (C): _____

E-MAIL _____

REFERRING PHYSICIAN:_____

A REPORT WILL BE SENT TO THE REFERRING PHYSICIAN AND HOME.

OTHER FACILITIES NEEDING RESULTS (must include an address and/or fax number):

_____

_____

GENERAL INFORMATION:

1. Has your child ever been evaluated for CAPD before? Yes _____ No _____
   If yes, where & when? _____
   Describe Results:_____
2. Does your child have any of the following diagnoses?
   - Learning Disability Yes _____ No _____
   - Speech/Language Disorder Yes _____ No _____
   - ADD or AD/HD (circle which applies) Yes _____ No _____
     If yes, is medication prescribed? Yes _____ No _____
     Is medication currently being taken? Yes _____ No _____
   - Other diagnosis: _____
3. Language(s) spoken in child's home:_____
   If more than one language is spoken in home:
   What is parents' primary language? _____
   When did child start speaking/learning English?_____

EDUCATIONAL INFORMATION:

1. School: _____ District: _____ Grade: _____
2. Academic Performance is:
   Above Average ___ Average ___ Below Average ___
   Varies based on subject (describe):_____
3. Does your child have an IEP or 504 Plan? Yes _____ No _____
   *If child has IEP or 504, list mandated services:
   _____
   _____

*****PLEASE BRING A COPY OF CHILD'S IEP OR 504 PLAN TO APPOINTMENT*****

4. Does your child receive support services other than those on an IEP/504 Plan? Yes _____ No _____
   If yes, describe: _____
5. Does your child have difficulty with:
   Phonics Yes _____ No _____
   Spelling Yes _____ No _____
   Reading Comprehension Yes _____ No _____
6. How would you rate your child's vocabulary?
   Excellent ___ Good ___ Fair ___ Poor ___
7. What is your child's IQ? _____
8. Please note any other pertinent educational information: _____
   _____

SYMPTOMS:

1. What behaviors or symptoms make you suspect that your child may have an auditory processing disorder?
   _____
2. Has your child's teacher and/or therapists expressed concern with auditory processing? Yes _____No ____
   If yes, please explain: _____
   _____
3. Describe your child's attention span:_____
   _____
4. Does your child have any behavior problems at home or at school? Yes _____ No ____
   If yes, please describe: _____
   _____
5. Is your child easily distracted? Yes _____ No ____
6. Does your child say "what" or "huh" frequently? Yes _____ No ____
7. Does your child seem confused by multiple instructions? Yes _____ No ____

8. Does your child forget what is said in a few minutes? Yes _____ No ____
9. Does your child confuse similar words or sounds? Yes _____ No ____
10. Do you often repeat directions to your child? Yes _____ No ____
11. Is your child easily frustrated? Yes _____ No ____
12. Is your child hyperactive? Yes _____ No ____
13. Please note any other relevant information:

_____

_____

_____

MEDICAL HISTORY:

1. Does your child have a history of frequent or recurrent ear infections? Yes _____ No _____
2. Has your child ever had ear tubes? Yes _____ No _____ If yes, when? _____
3. Does your child have a documented permanent hearing loss? Yes _____ No _____
4. Does your child have a chronic illness, disease, or syndrome? Yes _____ No ____

If yes, please explain:

_____

Please note any other pertinent medical information: _____

_____

_____

AUDIOLOGIST COMMENTS (FOR OFFICE USE ONLY):

_____

_____

_____

_____

_____

_____

_____

_____

Audiologist Signature_____ID#_____Date:_____Time:_____