



STONY BROOK UNIVERSITY MEDICAL CENTER

AUDITORY PROCESSING CASE HISTORY FORM FOR ADULTS

You must bring a prescription from your physician on the first day of the appointment or we will not be able to perform the test.

TODAY'S DATE: _____

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ ZIP: _____

PHONE (H): _____ (W): _____ (C): _____

E-MAIL _____

OCCUPATION _____

INSURANCE: _____ REFERRAL NEEDED? Y N

A REPORT WILL BE SENT TO THE REFERRING PHYSICIAN AND HOME IN APPROXIMATELY 10-14 DAYS.

Referred by _____

Person completing form Patient Spouse Other- Name _____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone
_____	_____	_____
_____	_____	_____

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

Name	Relationship to patient	Address	phone	fax
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name	Relationship to patient	Address	phone	fax
_____	_____	_____	_____	_____

I authorize the Department to disclose healthcare information to names above. Valid for one year.

Signature of Patient Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

Name: _____ DOB: _____

What type of difficulties have you been experiencing? _____

Have you been evaluated for APD in the past? _____

Have you received any other professional evaluations? (i.e. speech pathologist, neurologist, psychologist, etc) _____

If so, **Please include a copy of all results with this form.**

When did you first become concerned? _____

Do you have a documented hearing loss? YES _____ NO _____ If yes, please describe

Difficulty hearing in background noise	YES _____	NO _____	SOMETIMES _____
Hear better when watching the speaker	YES _____	NO _____	SOMETIMES _____
Are you easily distracted?	YES _____	NO _____	SOMETIMES _____
"Ignore people", especially if engrossed	YES _____	NO _____	SOMETIMES _____
Do you often need information repeated?	YES _____	NO _____	SOMETIMES _____
Difficulty remembering long instructions	YES _____	NO _____	SOMETIMES _____
Difficulty following conversations	YES _____	NO _____	SOMETIMES _____
Difficulty with rapid speech	YES _____	NO _____	SOMETIMES _____
Need more time to process information	YES _____	NO _____	SOMETIMES _____
Confuse similar sounding words	YES _____	NO _____	SOMETIMES _____
Poor Memorization skills	YES _____	NO _____	SOMETIMES _____
Difficulty taking notes	YES _____	NO _____	SOMETIMES _____
Spelling, reading, writing issues	YES _____	NO _____	SOMETIMES _____
Talk or likes TV louder than normal	YES _____	NO _____	SOMETIMES _____

AUDIOLOGIST COMMENTS (FOR OFFICE USE ONLY):

Audiologist signature _____ ID# _____ Date/Time: _____