



STONY BROOK UNIVERSITY MEDICAL CENTER

AUDITORY PROCESSING CASE HISTORY FORM

You must bring a prescription from your child's Doctor on day of your first 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.

TODAY'S DATE: _____

CHILD'S NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ ZIP: _____

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

E-MAIL _____ (in the event we are unable to reach you by phone)

INSURANCE: _____ REFERRAL NEEDED? Y N

Results will not be available on the day(s) of the evaluation as all results must be analyzed. A report will be ready by 10-14 days after testing is complete. The report will explain findings and recommendations for school and home. Parents may also contact the audiologist who completed the evaluation if they have any questions about the results.

Referred by _____

Person completing form Parent/Guardian Other-Name/Relationship _____

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: _____

GENERAL INFORMATION:

1. Child is: Right Handed _____ Left Handed _____ Mixed Dominant _____
2. Language(s) spoken in child's home: _____
 - a. If more than one language is spoken in home:
 What is parents' primary language? _____
 When did child start speaking/learning English? _____
3. Has your child ever been evaluated for CAPD before? Yes _____ No _____
 If yes, where? _____
 Describe Results: _____
4. Does your child have any of the following diagnoses?
 - Learning Disability* Yes _____ No _____
 - Mental Delays* Yes _____ No _____
 - Speech/Language Disorder* Yes _____ No _____
 - ADD or AD/HD* Yes _____ No _____
 - If yes, is medication prescribed? Yes _____ No _____
 - Is medication currently being taken? Yes _____ No _____
 - Results of medication: _____
 - Physician managing care: _____
 - Other diagnosis* Yes _____ No _____

If you answered yes to any of the above, please describe:

***IF YOU ANSWERED YES, PLEASE INCLUDE COPIES OF PROFESSIONAL EVALUATIONS/ REPORTS**

EDUCATIONAL INFORMATION:

1. Attends school at: _____
2. School District: _____
3. Grade Level: _____
4. Number of children in class: _____
5. School Performance is:
 Excellent ____ Above Average ____ Average ____ Below Average ____ Poor ____
6. Does your child like school? Yes _____ No _____
7. Has your child ever repeated a grade? Yes _____ No _____ If yes, which grade and why?

8. Does your child have an IEP or 504 Plan? Yes _____ No _____ If yes, what services are mandated?

***IF YES, PLEASE INCLUDE A COPY OF CHILDS IEP OR 504 PLAN**

9. Does your child receive any support services in school other than those on an IEP/504 Plan?
 Yes _____ No _____ If yes, describe: _____
10. Is your child better at some subjects than others? Yes _____ No _____ If yes, please list the stronger: _____
 List the weaker: _____

Name: _____ DOB: _____

11. Does your child have difficulty with:
- | | | |
|-----------------------|-----------|----------|
| Phonics | Yes _____ | No _____ |
| Spelling | Yes _____ | No _____ |
| Reading Mechanics | Yes _____ | No _____ |
| Reading Comprehension | Yes _____ | No _____ |
12. How would you rate your child's vocabulary?
Excellent ___ Good ___ Fair ___ Poor ___
13. What is your child's IQ? _____
14. Please note any other pertinent educational information:

MEDICAL HISTORY:

1. Your child was born: Full Term ___ Premature ___ If you answered premature, what was the length of pregnancy? _____
2. Describe any complications or concerns during pregnancy or childbirth: _____

3. Did your child stay in the NICU for any period of time after birth? Yes ___ No ___ If yes, why, and how long was the stay? _____
4. Does your child have a history of ear infections? Yes ___ No ___ If yes, how many times per year? _____ When was the last ear infection? _____
5. Has your child ever had ear tubes? Yes ___ No ___ If yes, when? _____
6. Does your child have a documented hearing loss? Yes ___ No ___ If yes, please describe _____
7. Have any immediate family members been diagnosed with an auditory processing disorder? Yes ___ No ___ If yes, who? _____
8. Did your child meet developmental milestones on schedule? Yes ___ No ___ If no, please explain: _____

9. Does your child have a chronic illness or disease? Yes ___ No ___ If yes, please explain: _____

10. Please list all medications your child is currently prescribed: _____

11. Please note any other pertinent medical information _____

Name: _____ DOB: _____

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 your child's 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. How would you describe your child's nature or personality? _____

6. Is your child easily distracted? Yes _____ No _____

7. Does your child say "what" or "huh" frequently? Yes _____ No _____

8. Does your child seem confused by multiple instructions? Yes _____ No _____

9. Does your child forget what is said in a few minutes? Yes _____ No _____

10. Does your child confuse similar words or sounds? Yes _____ No _____

11. Do you often repeat directions to your child? Yes _____ No _____

12. Is your child easily frustrated? Yes _____ No _____

13. Is your child hyperactive? Yes _____ No _____

14. Please note any other relevant information:

Audiologist Comments (For Office Use Only):

Audiologist signature _____ ID# _____ Date/Time: _____