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:
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: __________________