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Date:

PEDIATRIC HEARING ASSESSMENT INTAKE

All questions contained in this questionnaire are strictly confidential
and will become part of your child's record.

Child's Name *(Last, First,)*	☐ M ☐ F	**DOB:**
Referred From: ☐ Early Intervention ☐ Preschool ☐ Physician ☐ Private ☐ School District ☐ Other: _____		
Parent (s) Name :		**Date of Last Physical Exam:**
Pediatrician Name:		**ENT (Ear,Nose and Throat) Physician:**

Describe your child's challenges:				
Please describe your concerns about how your child hears: Does he/she:	☐ Yes ☐ No	Respond if you call from another room?	☐ Yes ☐ No	Alert to familiar sounds-ex: telephone
	☐ Yes ☐ No	Respond to his/her name?	☐ Yes ☐ No	Stop what he/she is doing when there is an unfamiliar sound?
	☐ Yes ☐ No	Try to look toward the sound source?	☐ Yes ☐ No	Recognize sounds in environment? Example: microwave beeping means food is ready.
List any medical problems that other doctors have diagnosed:				

Speech/Language: Do you have concerns about how your child talks?		**Comments:**
	Does your child?	
☐ Yes ☐ No	Use different cries to communicate meaning?	
☐ Yes ☐ No	Coos or babbles using different sounds?	
☐ Yes ☐ No	Say at least 10 words?	
☐ Yes ☐ No	Say 2-3 word sentences?	
☐ Yes ☐ No	Speak clearly to family?	
Developmental Milestones: Does your child have difficulty in:		**Describe:**
☐ Yes ☐ No	Physical development (balance, walking, sitting up,rolling over)	
☐ Yes ☐ No	Social/Emotional development (emotions and moods, interactions with others)	
☐ Yes ☐ No	Adaptive development (transitions and responds to change)	
☐ Yes ☐ No	Communication development (using and understanding language)	
☐ Yes ☐ No	Cognitive development (thinking skills)	

Behavior: Do you have concerns about your child's behavior? (tantrums, hitting, not following directions)		

Please continue to page 2

BIRTH/FAMILY/MEDICAL HISTORY

Birth History	Complications or medical conditions during pregnancy?	☐ Yes	☐ No
	If yes, what kind?		
	Length of pregnancy: Type of delivery?		
	Did your child pass newborn hearing screenings?	☐ Yes	☐ No
	If no, was there a follow up and where?	☐ Yes	☐ No
	Complications during birth?	☐ Yes	☐ No
	Neonatal intensive care visit? For how long?	☐ Yes	☐ No
		☐ Yes	☐ No
Family History	Are there any hearing issues in the family?	☐ Yes	☐ No
	Please describe:		
	Does someone in the family wear hearing aids?	☐ Yes	☐ No
Medical History	Has your child had ear infections? How many?	☐ Yes	☐ No
	How were they treated?		
	How many sets of tubes? Last surgery for tube placement?		
	Is your child on any medications?	☐ Yes	☐ No
	Describe:		
	Does your child have vision problems?	☐ Yes	☐ No

GENERAL INFORMATION

Is your child receiving Early Intervention services?	☐ Yes	☐ No
What services are they receiving and frequency?		
Who is your service coordinator?		
Is your child in a daycare or preschool setting? Where?		
Does your child play well with other children?	☐ Yes	☐ No
Do they have any special fears?	☐ Yes	☐ No
Is behavior consistent from day to day?	☐ Yes	☐ No