



Pediatric Therapies for Independent Lives

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Auditory Processing Case History Form

Today's date: _____

Patient's name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ (C): _____

Insurance: _____ Referral Needed? Yes No

Please note that not all insurances will cover the cost of this testing. Please contact your insurance company for more information regarding coverage. We will bill participating insurance companies for testing; however you will be responsible for your copay and any applicable non-covered portion.

Referred by: _____

Person completing form: _____

Relationship to patient: Parent/Guardian Self Other: _____

Results will be sent to names/locations listed below if address or fax number is provided.

Name	Address or Fax	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize Hear 2 Learn, PLLC to disclose the results of this evaluation to those listed above:

Signature

Relationship to patient: Parent/Guardian Self

Printed Name: _____

Results will not be available on the day 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 contact the audiologist who completed the evaluation if they have any questions about the results.

****Results of Speech/Language testing and an Educational Psychology evaluation must be provided for review prior to completion of Auditory Processing testing. This is because we want to be able to view your child's skills as a whole to best meet their needs.**

Name: _____ DOB: _____

Reason(s) for testing (check all that apply):

- Academic concerns
- Reading/phonics problems
- Speech/language problems
- Attention problems
- Hearing concerns
- Other: _____

Home and Family Information:

Father's Name: _____ Age: _____
 Occupation: _____
 Mother's Name: _____ Age: _____
 Occupation: _____
 Child lives with: _____
 Language(s) spoken at home: _____

Other children in the family:

Name	Age	Sex	Grade	Speech, hearing, learning or medical problems

Birth History:

Was your child: Full term Premature – If so, what was length of pregnancy? _____

Please list any pregnancy/birth complications:

Was your child in the NICU for any period of time after birth? Yes No

If yes, how long was the stay? _____

Medical history:

Does your child have a history of ear infections? Yes No

If yes, how many? _____ When was the last ear infection? _____

Has your child ever had PE tubes? Yes No

If yes, when? _____

Does your child have a documented hearing loss? Yes No

If yes, please describe: _____

Have any immediate family members been diagnosed with an auditory processing disorder?

Yes No If yes, who? _____

Did your child meet developmental milestones on schedule? Yes No

If no, please explain: _____

Does your child have a chronic illness or disease? Yes No

If yes, please explain: _____

Name: _____ DOB: _____

Please list all medications your child is currently taking:

Please note any other pertinent medical information:

Has your child ever been evaluated for APD before? Yes No

If yes, where? _____

Describe results: _____

Has your child ever been diagnosed with any of the following?

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 to any of the above, please include copies of professional evaluations/reports.

Educational Information:

Is your child (circle one): Right handed Left handed Mixed dominant

School attended: _____

School district: _____

Grade: _____

Number of children in class: _____

My child's academic performance is:

Excellent Above average Average Below average Poor

Does your child like school? Yes No

Has your child ever repeated a grade? Yes No If yes, which grade and why?

Does your child have an IEP or 504 Plan? Yes No If yes, what services does your child receive?

Does your child receive any support services other than those on an IEP/504 Plan?

Yes No If yes, please explain: _____

Best school subject: _____

Weakest school subject: _____

Extracurricular activities: _____

Name: _____ DOB: _____

How would you rate your child’s vocabulary?

- Excellent Good Fair Poor

Has your child ever received speech/language therapy? Yes No

If yes, please explain: _____

Please check the following:	Yes	No		Yes	No
Trouble understanding TV			Involved with drugs		
Sensitivity to loud sounds			Appears confused in noisy places		
Trouble telling where sounds are			Often says “huh” or “what”		
Problems following directions			Mixes up sounds		
Difficulty with phonics			Difficulty with reading mechanics		
Difficulty with spelling			Difficulty with reading comprehension		
Difficulty pronouncing words/sounds			Small vocabulary compared to peers		
Easily distracted			Preference to play with older children		
Daydreams			Restless		
Forgetful			Problem sitting still		
Preference to play with younger children			Rowdiness		
Disruptive			Needs quiet to study		
Preference for solitary activity			Headaches		
Lacks motivation			Short attention span		
Easily frustrated			Temper tantrums		
Tires easily			Easily frustrated or confused		
Often tense or anxious			Hyperactive		
Uncooperative			Disobedient		
Clumsy			Shy		
Impulsive			Irritable		
Lacks self-confidence			Destructive		
Easily upset by new situations			Excessive talking		
Has a problem with time concept			Seeks attention		
Fakes illnesses			Does not complete assignments		
Underachiever			Dislikes school		

Has your child’s teacher ever expressed concerns with your child’s progress? Please explain:

Please list any other educational concerns:

