Pediatric Audiology Intake

Personal Information **Date of Intake: ____________**

Child's Name: ______________________ Date of Birth: ______________________
Gender: ☐ Male ☐ Female Hand Preferred: ☐ Right ☐ Left
Child's School ______________________ Grade ______________________

Parent/Guardian: ______________________ Relationship: ______________________
Date of Birth: ______________________ Email: ______________________
Occupation: ______________________ Employer ______________________

Parent/Guardian: ______________________ Relationship: ______________________
Date of Birth: ______________________ Email: ______________________
Occupation: ______________________ Employer: ______________________

Home Address: ______________________
City: ____________ State: ____________ Zip Code: ____________
Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Insurance Information

Ins. Carrier: ______________________
Ins. Holder: ______________________
Policy # ______________________ Group #

Pediatrician's Information

Pediatrician: ______________________ Send report? ☐ Yes ☐ No
Address: ______________________
City: ____________ State: ____________ Zip Code: ____________
Phone: ____________ Fax#

Referred by (if different from above):

Referral: ______________________ Send report? ☐ Yes ☐ No
Address: ______________________
City: ____________ State: ____________ Zip Code: ____________
Phone: ____________ Fax# ____________

Notice of Parental/Guarantor Responsibilities

- You are responsible for all the fees associated with the care your child receives.
- Payment is expected at the time of the service unless other arrangements have been made in advance.
- It is your responsibility to understand your benefits and all obligations set forth by your insurance company.

By signing below, I acknowledge that have read and understood the above information.

______________________ ______________________
Print Patient's Name Signature of Parent/Guardian

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Birth History

Prematurity: ☐ Yes ☐ No Gestational Age at Birth: weeks

Jaundice: ☐ Yes ☐ No

Complications during pregnancy/delivery:

Medical attention following birth:

Blood transfusion	☐ Yes	☐ No
Medications	☐ Yes	☐ No
Cleft Palate	☐ Yes	☐ No
Craniofacial Anomalies	☐ Yes	☐ No
Lack of Oxygen	☐ Yes	☐ No

Explain if yes

Developmental History

Does your child have delayed speech/language development? ☐ Yes ☐ No Explain:

Does your child have delayed motor development?
☐ Yes ☐ No Explain:

Does your child have Sensory issues?
☐ Yes ☐ No Explain:

Does your child receive Early Intervention Services? ☐ Yes ☐ No If So: ☐ Speech Therapy ☐ OT ☐ PT ☐ Sensory Integration ☐ Play Group

Medical History

Does your child present with any of the following medical conditions?
- ☐ Head trauma/injury
- ☐ Seizure disorders
- ☐ Visual problems
- ☐ Syndrome ______________________________
- ☐ Other ________________________________

Does your child have any of the following diagnoses?
- ☐ Seizure Disorder
- ☐ ADHD/ADD/Attention difficulties
- ☐ Anxiety and/or Depression
- ☐ Autism/PDD/Asperger's Disorder
- ☐ Learning Disability
- ☐ Language Disorder/Articulation Disorder
- ☐ Hearing Loss

Does your child currently take any medications? ☐ Yes ☐ No
If Yes, please list:

Does your child currently receive any outpatient therapy services? ☐ Speech/Language ☐ OT ☐ PT ☐ SI
☐ Other:

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Family History

Did/Does any family member have any of the following diagnoses:		Mother	Father	Sibling
	Seizure Disorder	☐	☐	☐
	ADHD/ADD	☐	☐	☐
	Anxiety/Depression	☐	☐	☐
	Autism/PDD/Asperger's	☐	☐	☐
	Learning Disability	☐	☐	☐
	Language Disorder	☐	☐	☐
	Articulation Disorder	☐	☐	☐
	Hearing Loss	☐	☐	☐
	Auditory Processing	☐	☐	☐
	Dyslexia	☐	☐	☐
	Genetic Syndromes	☐	☐	☐

Is your child adopted?	☐ Yes ☐ No
Please list any additional languages spoken in the home:	
Was your child's first language English?	
Please list any other important family history here:	

Hearing History

Did your child pass the newborn hearing screening?	☐ Yes ☐ No Follow-up:
When was your child's last hearing screening or evaluation?	Date: Results:
Does your child have a history of ear infections?	☐ Yes ☐ No Treated By: ☐ Antibiotics ☐ Tubes (# of sets)
Has your child ever had an auditory processing evaluation?	☐ Yes Results: ☐ No

Please explain reason for referral and concerns you have about your child's hearing

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****The following section is to be completed ONLY if your child will be receiving an Auditory Processing Evaluation****

Educational History

Current School: ______________________		District: ______________
Current Grade: ______________________		Repeated Grade? ☐ Yes ☐ No
Educational Setting:	☐ Regular Ed. ☐ Inclusion Ed.	☐ Other ______________________
Education Plan:	☐ 504 Accommodations ☐ Academic Instruct. Svs. (AIS)	☐ Individualized Ed Plan (IEP)
Current Therapies: ☐ None	☐ Speech/Language (/wk) ☐ Physical Therapy (/wk) ☐ Resource Room (/wk)	☐ Occupational Therapy (/wk) ☐ Reading Instruction (/wk) ☐ 1:1 Aide in Classroom (☐ part-time or ☐ full-time)
My child has difficulties with:	☐ Reading ☐ Spelling ☐ Phonics ☐ Foreign Language ☐ Other	☐ Math ☐ Organization ☐ Grammar ☐ Sciences

Visual Skills

Last visual examination?		
Does your child use glasses? ☐ Far-Sighted ☐ Near-Sighted ☐ Astigmatism	☐ Yes ☐ No How Long?	
Does your child:		
Lose place when reading?	☐ Yes	☐ No
Skip/re-read lines?	☐ Yes	☐ No
Skip/add-in words?	☐ Yes	☐ No
Notice words moving/running together?	☐ Yes	☐ No
Confuse words with similar endings/beginnings?	☐ Yes	☐ No
Complain of intermittent blur at near?	☐ Yes	☐ No
Does your child present with the following symptoms? ☐ None	☐ Eyestrain ☐ Headaches ☐ Eyes tear	☐ Rubs eyes ☐ Double Vision

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Previous Testing: **Please forward all recent educational reports for review prior to your child's appointment**

Discipline	Tests Administered	Results:	
Psychology	☐ WISC-IV ☐ WAIS ☐ Other:	Verbal: Processing Speed: Performance: Working Memory: Full Scale:	Neuropsychological Testing (if applicable). Please list:
Speech	Tests:	Receptive:	
		Expressive:	
		Integrative:	
		Pragmatic:	
		Articulation:	
OT	Tests:	Fine Motor:	
		Visual Motor:	
		Visual Perceptual:	
		Sensory:	
Education	Tests:	Written Expression:	
		Reading:	
		Spelling:	
		Math:	
		Other:	

Please feel free to inform us of any other pertinent information regarding your child in the space below: