HEAR CLEARLY

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Pediatric Audiological History Form

Name (child's)________________________ Home Phone________________ Date______

Father's Name____________ Occupation________ Work Phone.#__________ Cell#____________

Mother's Name______________ Occupation__________ Work Phone.#__________ Cell#___________

Sibling's Name & Age____

Referred by_________________________ Date of Evaluation ______/_____/______

What is your child's first language? ______________

What is the primary language spoken in the home?________________________

DESCRIPTION OF PROBLEM

Briefly describe problem ____

When was it first noticed?____

What was done about it? ____

SPEECH & HEARING DEVELOPMENT

Does child respond to sound?____

Does child respond to spoken directions and questions?_____________________________

Does child appear to hear adequately? ____________________________________

Does child appear to be developing speech & language normally? _______________________

How many words does your child have in his/her vocabulary?___________________________

Does your child put words together?__________If yes, 2-3__________../or more_________(check one)

Does any family member (including aunts, uncles grandparents) have a hearing and/or speech impairment? _____

Does your child wear a hearing aid? If yes, make ____________________ Model____________________

Right___________ Left______________ Binaural____________

Referred by?__________________ When?_______________

LABOR. PREGNANCY & DELIVERY

Did mother have any accidents, illness, or other unusual conditions such as Rh negative during pregnancy?

____

Did mother have full term (9 month) pregnancy with child? ____________________

Was labor, delivery and development normal? If no, please explain ____________________

____

Were there any problems at birth? If yes, please explain ____________________

____

Apgar Score was **1 2 3 4 5 6 7 8 9 10 (Circle one)**

Was the child "blue" or "yellow" at birth? ____________________

Was light therapy utilized? ____________________

Were there any drugs used? ____________________

Did child pass newborn hearing screening? Yes__________ No__________

At what age did child hold head erect ______________ Walk unaided ______________

Become toilet trained ____ Say first words _____

MEDICAL HISTORY

Did your child have immunization for childhood diseases? (I.e. measles, mumps, chicken pox). If not, did he or she have any of those listed or any other? ____________________

____

Does child have chronic colds, allergies, sore throats or tonsil and adenoid problems? If yes, please circle.

Has your child had ear Infections? If yes, how many and when was the last one? Please describe treatment.

____

Does your child take any medication? ______ If yes, name and dose ____________________

Has your child been hospitalized? If yes, why, when, where? ____________________

____

Does your child have sleep problems (I.e:. snoring, apnea)? ____________________

EDUCATIONAL HISTORY

Does your child attend school? __________

What grade? ____________________ If yes, where? ____________________

Does your child have an IEP? ____________________ Classification ____________________

What special services does your child receive? ____________________

Circle all that apply

Speech/language ____________	group/individual
OT ____________	group/individual
PT ____________	group/individual
ABA ____________	group/individual
Counseling ____________	group/individual