

THE WALDRON COLLEGE OF HEALTH AND HUMAN SERVICES
Radford University Speech-Language and Hearing Clinic
Radford University
P. O. Box 6961
Radford, VA 24142
(540) 831-7166
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Pediatric Auditory Processing Evaluation
Case History Form

Patient Information:

Date Form Completed: _____
Child's Name: _____ Date of Birth: _____
Address: _____
Phone: _____

Person completing the form: _____
Relationship to Child: _____
Does child live with both parents? _____

Mother's Name: _____ Age: _____
Mother's Occupation: _____ Work Phone: _____

Father's Name: _____ Age: _____
Father's Occupation: _____ Work Phone: _____

Brothers and Sisters (Please include names and ages):

Referred by: _____ Phone: _____
Address: _____
Pediatrician: _____ Phone: _____
Address: _____

Besides yourself, who should receive copies of the evaluation report? (Please provide addresses): _____

Educational Information:

1. Attends school at: _____
 2. Grade Level: _____
 3. School Performance is:
 Excellent Above average Average Below average Poor
 4. Has your child ever repeated a grade? NO YES. If yes, which grade and why? _____
 5. Does your child receive special assistance in school (i.e. remedial reading, resource room, speech therapy, etc.)? NO YES. If yes, please explain.

 6. Is your child better at some subjects than others? NO YES. If yes, please list the stronger. _____
Weaker. _____
 7. Does your child have difficulty with:
Phonics NO YES
Spelling NO YES
Reading Mechanics NO YES
Reading Comprehension NO YES
 8. Do you think your child has a language problem (i.e. understanding language, using appropriate language, etc.)? NO YES. If yes, please explain.

 9. How would you rate your child's vocabulary?
 Excellent Good Fair Poor
 10. Does your child have a diagnosis of any of the following?
* Learning Disability NO YES
* Mental Delays NO YES
* Speech/Language Disorder NO YES
- (If you answered yes to any of the previous conditions, the results of the AP evaluation may not be reliable as some deficits interfere with basic auditory processing functions.)

Medical History:

1. Your child was born Full-term Premature. If you answered Premature, how early into the pregnancy was your child born? _____
2. Describe any complications or concerns during the birthing process.

3. Did your child stay in the Neonatal Intensive Care Unit (NICU) for any period of time after birth? NO YES. If yes, why and how long was the stay?

4. Did your child undergo any medical or surgical treatment upon birth?
 NO YES. If yes, please list treatment received. _____

5. Does your child have a history of ear infections? NO YES. If yes, how many times per year? _____ When was the last ear infection? _____

6. Has your child ever had ear tubes to treat the ear infections?
 NO YES. If yes, when? _____

7. Does your child have a documented hearing loss? NO YES. If yes, explain the type of loss to the best of your knowledge. _____

8. Is there a family history of hearing loss? NO YES. If yes, list who and any details that you know. _____

9. Have any immediate family members been diagnosed with an AP disorder?
 NO YES. If yes, list who and any details that you know. _____

10. Did your child reach developmental milestones on schedule? NO YES. If no, please explain. _____

11. Please list all childhood diseases.

12. Please list all medications your child is currently prescribed.

Symptoms:

1. What behaviors or symptoms make you suspect that your child may have an auditory processing disorder? _____

2. Please answer the following:

Does your child demonstrate difficulty hearing? NO YES

Does your child say "huh" or "what" frequently? NO YES

Can your child remember multiple-step directions? NO YES

Do you often repeat instructions? NO YES

Does your child often forget what is said? NO YES

Does your child often misunderstand what is said? NO YES

Does your child confuse similar words or sounds? NO YES

Is your child easily distracted by background noise? NO YES

Does your child often show frustration/lack of motivation? NO YES

Would you consider your child hyperactive? NO YES

Does your child have a short attention span? NO YES

3. Does your child have any behavior problems at home or in the classroom?
 NO YES. If yes, please explain. _____

4. Has your child been diagnosed with an attention deficit disorder? NO YES

If yes, explain when. _____. Has any medication been prescribed for this problem? NO YES. If yes, what is the medication? _____ Dosage? _____
Results of taking the medication? _____

5. Is there any additional information you think would be beneficial for us to know?

At their convenience, parents are asked to provide the following:

- Completed Case History Form
- Copies of diagnostic evaluations that have been done by other professionals prior to scheduling the evaluation; these may include school psychoeducational evaluations, IEPs (Individualized Education Plan), Psychological Testing, physicians' notes, Speech Language Evaluation and other related records

Appointments for an AP evaluation will only be scheduled upon receipt of the information listed above. All information can be delivered in person, mailed, or faxed to the Radford Speech-Language and Hearing Clinic.