Stony Brook Medicine

STONY BROOK UNIVERSITY MEDICAL CENTER

AUDITORY PROCESSING CASE HISTORY FORM

You must bring a prescription from your child's Doctor on day of your first appointment or we will not be able to perform the test.
If you are being referred by a school district, you must consult with your MD and request a prescription.

TODAY'S DATE: _____

CHILD'S NAME: _____ DOB: _____
ADDRESS:_____
CITY:_____ZIP**:**_____
PHONE (H): _____ (W): _____ (C): _____
E-MAIL _____ (in the event we are unable to reach you by phone)

INSURANCE: _____ REFERRAL NEEDED? Y N

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

Referred by _____
Person completing form □Parent/Guardian □ Other-Name/Relationship _____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

Name	Relationship to patient	Address	phone	fax
Name	Relationship to patient	Address	phone	fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.

Signature of □ Patient □ Parent/Guardian _____ Date _____
Printed Name of Parent/Guardian _____

Name: _____ DOB:_____

GENERAL INFORMATION:

1. Child is: Right Handed _____ Left Handed _____ Mixed Dominant _____
2. Has your child ever been evaluated for CAPD before? Yes _____ No _____
   If yes, where? _____
   DescribeResults:_____
   _____
3. Does your child have any of the following diagnoses?
   - 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, PLEASE INCLUDE COPIES OF PROFESSIONAL EVALUATIONS/ REPORTS**

EDUCATIONAL INFORMATION:

1. Attends school at: _____
2. School District: _____
3. Grade Level: _____
4. Number of children in class: _____
5. School Performance is:
   Excellent ___ Above Average ___ Average ___ Below Average ___ Poor ___
6. Does your child like school? Yes _____ No _____
7. Has your child ever repeated a grade? Yes _____ No _____ If yes, which grade and why?
   _____
8. Does your child have an IEP or 504 Plan? Yes _____ No _____ If yes, what services are mandated? _____
   _____
   ***IF YES, PLEASE INCLUDE A COPY OF CHILDS IEP OR 504 PLAN**
9. Does your child receive any support services in school other than those on an IEP/504 Plan? Yes _____ No _____ If yes, describe: _____
10. Is your child better at some subjects than others? Yes _____ No _____ If yes, please list the stronger:_____
    List the weaker:_____

Name: _____ DOB:_____

11. Does your child have difficulty with:
    - Phonics Yes _____ No _____
    - Spelling Yes _____ No _____
    - Reading Mechanics Yes _____ No _____
    - Reading Comprehension Yes _____ No _____
12. How would you rate your child's vocabulary?
    Excellent ___ Good ___ Fair ___ Poor ___
13. What is your child's IQ? _____
14. Please note any other pertinent educational information:

_____
_____
_____

MEDICAL HISTORY:

1. Your child was born: Full Term ____ Premature ____ If you answered premature, what was the length of pregnancy? _____
2. Describe any complications or concerns during pregnancy or childbirth: _____
_____
_____
3. Did your child stay in the NICU for any period of time after birth? Yes _____ No _____ If yes, why, and how long was the stay? _____
4. Does your child have a history of ear infections? Yes _____ No _____ If yes, how many times per year? _____ When was the last ear infection? _____
5. Has your child ever had ear tubes? Yes _____ No _____ If yes, when? _____
_____
6. Does your child have a documented hearing loss? Yes _____ No _____ If yes, please describe
_____
7. Have any immediate family members been diagnosed with an auditory processing disorder? Yes _____ No _____ If yes, who? _____
8. Did your child meet developmental milestones on schedule? Yes _____ No _____ If no, please explain: _____
_____
9. Does your child have a chronic illness or disease? Yes _____ No ____ If yes, please explain:
_____
_____
10. Please list all medications your child is currently prescribed: _____
_____
11. Please note any other pertinent medical information
_____
_____
_____

Name: _____ DOB:_____

SYMPTOMS:

1. What behaviors or symptoms make you suspect that your child may have an auditory processing disorder?
   _____
   _____
   _____
   _____
2. Has your child's teacher and/or therapists expressed concern with your child's auditory processing? Yes _____ No ____ If yes, please explain: _____
   _____
   _____
3. Describe your child's attention span:_____
   _____
4. Does your child have any behavior problems at home or at school? Yes _____ No ____ If yes, please describe: _____
   _____
5. How would you describe your child's nature or personality? _____
   _____
   _____
6. Is your child easily distracted? Yes _____ No ____
7. Does your child say "what" or "huh" frequently? Yes _____ No ____
8. Does your child seem confused by multiple instructions? Yes _____ No ____
9. Does your child forget what is said in a few minutes? Yes _____ No ____
10. Does your child confuse similar words or sounds? Yes _____ No ____
11. Do you often repeat directions to your child? Yes _____ No ____
12. Is your child easily frustrated? Yes _____ No ____
13. Is your child hyperactive? Yes _____ No ____
14. Please note any other relevant information:
    _____
    _____
    _____

Audiologist Comments (For Office Use Only):

_____

_____

_____

_____

_____

_____

_____

_____

Audiologist signature _____ID# _____ Date/Time:_____