

**STONY BROOK UNIVERSITY MEDICAL CENTER**

**AUDITORY PROCESSING CASE HISTORY FORM**



**You must bring a PRESCRIPTION from your child's DOCTOR on the day of your 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.

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PERSON COMPLETING FORM: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

PHONE (H): \_\_\_\_\_ (C): \_\_\_\_\_

E-MAIL \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

**A REPORT WILL BE SENT TO THE REFERRING PHYSICIAN AND HOME.**

OTHER FACILITIES NEEDING RESULTS (must include an address and/or fax number):

\_\_\_\_\_  
\_\_\_\_\_

**GENERAL INFORMATION:**

1. Has your child ever been evaluated for CAPD before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, where & when? \_\_\_\_\_

Describe Results: \_\_\_\_\_

2. Does your child have any of the following diagnoses?

• Learning Disability Yes \_\_\_\_\_ No \_\_\_\_\_

• Speech/Language Disorder Yes \_\_\_\_\_ No \_\_\_\_\_

• ADD or AD/HD (circle which applies) Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, is medication prescribed? Yes \_\_\_\_\_ No \_\_\_\_\_

Is medication currently being taken? Yes \_\_\_\_\_ No \_\_\_\_\_

• Other diagnosis: \_\_\_\_\_

3. Language(s) spoken in child's home: \_\_\_\_\_

If more than one language is spoken in home:

What is parents' primary language? \_\_\_\_\_

When did child start speaking/learning English? \_\_\_\_\_

**EDUCATIONAL INFORMATION:**

1. School: \_\_\_\_\_ District: \_\_\_\_\_ Grade: \_\_\_\_\_

2. Academic Performance is:

Above Average \_\_\_\_ Average \_\_\_\_ Below Average \_\_\_\_

Varies based on subject (describe): \_\_\_\_\_

3. Does your child have an IEP or 504 Plan? Yes \_\_\_\_ No \_\_\_\_

\*If child has IEP or 504, list mandated services:

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*PLEASE BRING A COPY OF CHILD'S IEP OR 504 PLAN TO APPOINTMENT\*\*\***

4. Does your child receive support services other than those on an IEP/504 Plan? Yes \_\_\_\_ No \_\_\_\_

If yes, describe: \_\_\_\_\_

5. Does your child have difficulty with:

Phonics Yes \_\_\_\_ No \_\_\_\_

Spelling Yes \_\_\_\_ No \_\_\_\_

Reading Comprehension Yes \_\_\_\_ No \_\_\_\_

6. How would you rate your child's vocabulary?

Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

7. What is your child's IQ? \_\_\_\_\_

8. Please note any other pertinent educational information: \_\_\_\_\_

\_\_\_\_\_

**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 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. Is your child easily distracted? Yes \_\_\_\_ No \_\_\_\_

6. Does your child say "what" or "huh" frequently? Yes \_\_\_\_ No \_\_\_\_

7. Does your child seem confused by multiple instructions? Yes \_\_\_\_ No \_\_\_\_

- 8. Does your child forget what is said in a few minutes? Yes \_\_\_\_\_ No \_\_\_\_\_
- 9. Does your child confuse similar words or sounds? Yes \_\_\_\_\_ No \_\_\_\_\_
- 10. Do you often repeat directions to your child? Yes \_\_\_\_\_ No \_\_\_\_\_
- 11. Is your child easily frustrated? Yes \_\_\_\_\_ No \_\_\_\_\_
- 12. Is your child hyperactive? Yes \_\_\_\_\_ No \_\_\_\_\_
- 13. Please note any other relevant information:

---

---

---

**MEDICAL HISTORY:**

- 1. Does your child have a history of frequent or recurrent ear infections? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Has your child ever had ear tubes? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_
- 3. Does your child have a documented permanent hearing loss? Yes \_\_\_\_\_ No \_\_\_\_\_
- 4. Does your child have a chronic illness, disease, or syndrome? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain:

---

Please note any other pertinent medical information: \_\_\_\_\_

---

---

**AUDIOLOGIST COMMENTS** (FOR OFFICE USE ONLY):

---

---

---

---

---

---

---

---

---

---

Audiologist Signature \_\_\_\_\_ ID# \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_