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AUDITORY PROCESSING DISORDER (APD) CASE HISTORY

adapted from APD Case History AFA Balance & Hearing Institute

Please fill out this form as completely as possible. This information is crucial for our evaluation process; your input gives us insight into your child's every day level of functioning. If you answer yes to any questions please try to give comments.

**Please Note: After completion, please return this form, along with any other pertinent academic/medical information (i.e. IEP, reports from other clinicians or therapists your child has seen) to the center.*

Date: _____

Child's Name: _____

Child's Date of Birth: _____ Age:_____ Sex:_____ Grade in School:_____

Father's Name: _____ Mother's Name:_____

Date of Birth: _____ Date of Birth:_____

Father's Address: _____ Mother's Address:_____

_____ _____

Father's Employer: _____ Mother's Employer:_____

Position:_____ Position:_____

Father's telephone (H) _____ Mother's telephone: (H)_____

(W) _____ (W)_____

(C)_____ (C)_____

Parent's marital Status: S M D W

Child Lives with (check one): _____ Birth Parents ____Foster Parents _____One Parent

_____Adoptive Parents ____Parent and Stepparent _____Other _____

Ethnicity: African American Asian Caucasian Hispanic/Latino Other_____

Primary Language Spoken in home/ by primary caregiver: _____/_____

Primary Language Spoken by child in home: _____Other Languages Spoken: _____

Primary Insurance_____ Phone _____

Address: _____ ID#_____

Card Holder Name: _____ Card Holder DOB _____

Secondary Insurance_____ Phone _____

Address: _____ ID#_____

Card Holder Name: _____ Card Holder DOB _____

Medical History:

1. Were there complications during the pregnancy? Yes No

   If yes, describe: _____

2. Were there complications during the birth? Yes No

   If yes, describe: _____

3. Did your child have a premature birth? Yes No

   If yes, how many weeks? _____

4. Did your child stay in the Neonatal Intensive Care Unit (NICU) for any period of time after birth? Yes No

   If yes, describe: _____

5. Did your child reach developmental milestones on schedule? Yes No

   If no, please explain_____

6. Has your child had any serious illness or accidents? Yes No

   If yes, describe _____

7. Please check if your child had any of the following:

□ Fetal alcohol syndrome	□ Ototoxic medication	□ Asphyxia
□ Hyperbilirubinemia	□ Mechanical Ventilation	□ Head/neck deformity
□ Bacterial Meningitis	□ Fever over 104° F	□ Craniofacial abnormalities
□ Congenital Perinatal infections	□ Maternal substance abuse	□ Syndromal abnormality

Otological History:

1. Does your child have a history of ear problems? Yes No

   Please check all that apply:

   □ Ear infections □ Ear aches □ Ear canal discharge

   □ Excessive ear wax □ Tubes in the ear □ Hole/perforated eardrum

   □ Fluid behind the ear □ Soreness/pain in the ears □ Other: _____

2. Approximate how many episodes of ear problems since birth? _____

3. Has your child had an ear infection in the last 6 months? Yes No

   If yes, when? _____

   What type? _____

   Was medication given? Yes No What? _____

4. Is there a family history of childhood hearing loss? Yes No

   If yes, who? _____

   What type? _____

5. Has your child ever been treated by an Ear, Nose & Throat (ENT) doctor? Yes No

   If yes, who? _____

When? For What? _____

What treatment was given? _____

6. Has your child previously had his/her hearing tested by an Audiologist? Yes No

   If yes, where? _____

   When? _____

   What were the results? _____

7. Please list all medical diagnosis (i.e. autism, down syndrome, hearing loss, ADHD)?

   _____

8. Has your child had a vision exam? Yes No

   If yes, what were the results? _____

9. Does your child have any allergies? (Food, medication, environmental?) _____

   _____

Educational History

School: _____ Grade: _____ Teacher:_____

Student's preferred hand: Right Left Repeated a grade? Yes No

School performance is: Excellent Above Average Average Below Average

1. Does your child have difficulties with any subjects at school? If yes, please list: -

   _____

2. What are your child's best subjects in school? _____

3. What is your child's attitude towards school? _____

4. Has your child been tutored? _____

   If yes, please describe:_____

5. Has your child ben evaluated for learning problems? Yes No

6. Does your child have any learning problems? Yes No

   If yes, describe? _____

7. Does your child participate in any special classes or have an individualized education plan (IEP) or 504 Plan?

   Yes No _____

8. Has your child been evaluated by a Speech Language Pathologist and/or Occupational Therapist? Yes No

9. Has your child received or are they currently receiving speech therapy? Yes No

   Where _____ how often? _____

10. Has your child received or are they currently receiving occupational therapy? Yes No

    Where _____ how often? _____

11. Does your child have any known behavioral problems? Yes No

If yes, describe: _____

Behavior and Characteristics:

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

_____

_____

2. Do you think your child has problems listening or understanding? Yes No

   If yes, explain: _____

   How long have you been aware of this problem? _____

3. Please check if your child exhibits any of the following behaviors or characteristics:

Audiology:

□ Sensitive to loud sounds
□ Appears confused in noisy places
□ Easily distracted by background noise
□ Misunderstands oral directions and instructions*
□ Difficulty following oral directions and instructions*
□ Difficulty following/understanding TV program*
□ Difficulty understanding speech in background noise*

□ Says "what" or "huh" frequently*
□ Often asks for repetition*
□ Delays in responding to oral instructions/questions*
□ Difficulty with phonics or discriminating speech sounds*
□ Difficulty with rhyming*
□ Difficulty pronouncing words, sounds correctly*
□ Poor listener

Speech Therapy: (*noted in audiology section)

□ Gives inappropriate responses to questions
□ Poor receptive or expressive language
□ Inappropriate social behavior
□ Difficulty telling stories/recalling events
□ Reverses words, numbers or letters

Occupational Therapy:

□ Responds negatively to loud or unexpected noises
□ Asks for the TV or radio to be lowered
□ Easily upset in new situations
□ Reluctant to try a new task
□ Appears clumsy or uncoordinated
□ Seems to do things either too hard or too light
□ Craves jumping or falling into objects/people
□ In constant motion, difficulty sitting still

All Disciplines:

□ Prefers to play with older children
□ Prefers to play with younger children
□ Prefers solitary activities
□ Seeks attention
□ Shy
□ Lacks self-confidence
□ Easily frustrated
□ Uncooperative
□ Depressed
□ Difficulty sleeping
□ Interrupts/intrudes
□ Difficulty making friends

□ Trouble following routines
□ Hyperactive
□ Disruptive or rowdy
□ Short attention span/inattentive
□ Anxious
□ Impulsive
□ Difficulties recalling short/long term information
□ Forgetful
□ Daydreams
□ Dislikes school
□ Spelling, reading or other academic concerns

□ Gets nauseous from movement (swing, car rides)
□ Does not like getting messy or dirty
□ Avoids certain textures of clothing
□ Has difficulty with puzzles
□ Skips lines when reading or writing
□ Has difficulty with writing and/or fine motor skills
□Tires easily with motor tasks/poor endurance
□ Slumps or holds their head in their hand when sitting at desk or table

Is there any additional information you feel would be beneficial for us to know? (such as stressors in the home life e.g. a new baby, death in the family, a new home, recent changes in schedules)

_____

_____

_____

_____

This form was completed by: _____ Relationship _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

Persons/Organizations receiving the information:

(Please include any /all of the professionals involved in the care of the client for the current diagnosis for which he/she is being seen.) Please include name and phone number. This information will be used to assist in providing the most comprehensive care to the client.

Primary Care Physician /Pediatrician: _____ Address_____

Audiologist: _____ Address_____

G.I.:_____ Address_____

Neurologist: _____ Address_____

Physical Therapist: _____ Address_____

Occupational Therapist_____ Address_____

Speech Therapist: _____ Address_____

Other: _____ Address_____

Name of School: _____ Address_____

Teacher: _____ Grade: _____

My signature authorizes Blue Ridge Speech & Hearing Center the disclosure or use of my medical information with the above indicated professionals.

_____ _____

Signature of child's representative Date

_____

Printed name of child's representative

_____

Relationship to child