CLEARCHOICE
HEARING AND BALANCE

Auditory Processing Case History Form

Child's Name:_____DOB:_____

Address:_____

City:_____Zip:_____Phone:_____

Email:_____

Parent/Guardian:_____ Phone #:_____

Primary Care Doctor: _____ Phone #:_____

Insurance:_____ Guarantor:_____

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 completed. 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.

GENERAL INFORMATION

1. Child is: Right handed___ Left Handed___ Mixed Dominant___
2. Language(s) spoken in child's home:_____
    - If more than one language is spoken in home what is the primary language?_____
3. Has your child ever been evaluated for CAPD before? Yes__ No __
    - If yes, where?_____
    - Describe results:_____
      _____
4. Does your child have any of the following diagnoses?
    - Learning Disability: Yes__ No__
    - Mental Delays: Yes__ No__
    - Speech/Language Disorder: Yes__ No__
    - ADD or ADHD: Yes__ No__
        i. If yes, is medication prescribed? Yes__ No__
        ii. Is medication currently being taken? Yes__ No__
        iii. Results of medication:_____
    - Other diagnosis: Yes__ No__

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If you answered yes to any of the above, please describe

_____

_____

***IF YOU ANSWERED YES, PLEASE INCLUDE COMPIES OF PROFESSIONAL EVALUATIONS/REPORTS**

EDUCATIONAL INFORMATION

- Attends school at: _____
- School District: _____
- Grade Level: _____
- Number of children in class: _____
- School Performance is:

  Excellent __ Above average __ Average __ Below Average __ Poor __

- Does your child like school? Yes __ No __
- Has your child repeated a grade? Yes __ No __ If yes, which grade and why?_____
- Does your child have a 504 or IEP? Yes __ No __ If yes, what services are mandated?

  _____

  ***IF YES, PLEASE INCLUDE A COPY OF CHILDS IEP OR 504 PLAN**
- Does your child receive any support services in school other than those on an IEP/504 Plan? Yes __ No __ If yes, describe: _____
- Is your child better as some subjects than others? Yes __ No __ If yes, please list the stronger:_____
  List the weaker: _____
- Does your child have difficulty with:

Phonics	Yes __ No __
Spelling	Yes __ No __
Reading Mechanics	Yes __ No __
Reading Comprehension	Yes __ No __

- How would you rate your child's vocabulary?
  Excellent __ Good __ Fair __ Poor
- Please note any other pertinent educational information:

  _____

  _____

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MEDICAL HISTORY

- Your child was born: Full Term __ Premature __
- If you answered premature, what was the length of pregnancy? _____
- Describe any complications or concerns during pregnancy or childbirth:
  _____
  _____
- 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?
  _____
  _____
- Does your child have a history of ear infections? Yes __ No __
  If yes, how many times per year? _____
  When was the last ear infection? _____
- Has your child ever had ear tubes? Yes __ No __
  If yes, when? _____
- Does your child have a documented hearing loss? Yes __ No __
  If yes, please describe. _____
- Have any immediate family members been diagnosed with auditory processing disorder?
  Yes __ No __ If yes, who? _____