

Auditory Processing Case History Form

Child's Name: _____ DOB: _____

Address: _____

City: _____ Zip: _____ Phone: _____

Email: _____

Insurance: _____ Referred By: _____

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__

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:

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? _____