

## Auditory Processing Disorder Case History: Children

Name:	D.O.B:	Today's Date:
School:	Grade:	Teacher:
Classroom Type:	<input type="checkbox"/> Open Podium <input type="checkbox"/> Traditional <input type="checkbox"/> Portable	
Student's preferred hand:	<input type="checkbox"/> Right <input type="checkbox"/> Left	

Referring Physician:
Referring Physician Address:
Form Completed by:

**Developmental 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? \_\_\_\_\_  
 What was your child's APGAR score? \_\_\_\_\_  
 What was your child's birth weight? \_\_\_\_\_
4. Has your child had any serious illness or accidents?    Yes    No  
 If yes, describe: \_\_\_\_\_

Please check (✓) if your child had any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Fetal alcohol syndrome     | <input type="checkbox"/> Ototoxic medication             |
| <input type="checkbox"/> Asphyxia                   | <input type="checkbox"/> Hyperbilirubinemia              |
| <input type="checkbox"/> Mechanical Ventilation     | <input type="checkbox"/> Head/neck deformity             |
| <input type="checkbox"/> Bacterial Meningitis       | <input type="checkbox"/> Fever over 104° F               |
| <input type="checkbox"/> Craniofacial abnormalities | <input type="checkbox"/> Congenital Perinatal infections |
| <input type="checkbox"/> Maternal substance abuse   | <input type="checkbox"/> Syndromal abnormality           |

**Otological History:**

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

Please check (✓) all that apply:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ear infections            | <input type="checkbox"/> Ear aches                | <input type="checkbox"/> Ear canal discharge     |
| <input type="checkbox"/> Excessive ear wax         | <input type="checkbox"/> Tubes in the ear         | <input type="checkbox"/> Hole/perforated eardrum |
| <input type="checkbox"/> Fluids behind the eardrum | <input type="checkbox"/> Soreness/pain in the ear | <input type="checkbox"/> Other: _____            |

2. 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? \_\_\_\_\_  
Was Medicine given?  Yes  No What? \_\_\_\_\_
4. Is there a family history of ear problems?  Yes  No  
If yes, who? \_\_\_\_\_  
What type? \_\_\_\_\_  
Was Medicine given?  Yes  No What? \_\_\_\_\_
5. Has your child ever been treated by an Ear, Nose & Throat (ENT) doctor?  Yes  No  
If yes, who? \_\_\_\_\_  
When? For What? \_\_\_\_\_  
Was Medicine given?  Yes  No What? \_\_\_\_\_
6. Has your child ever had ear surgery?  Yes  No  
If yes, describe: \_\_\_\_\_  
When? \_\_\_\_\_
7. Has your child previously had his/her hearing tested by an Audiologist?  Yes  No  
If yes, where? \_\_\_\_\_  
When? \_\_\_\_\_  
What were the results? \_\_\_\_\_
8. Does your child have any permanent hearing loss?  Yes  No  
If yes, describe: \_\_\_\_\_
9. Has your child ever used amplification?  Yes  No  
If yes, describe: \_\_\_\_\_

**Other History:**

1. Does your child have any learning problems?  Yes  No  
If yes, explain: \_\_\_\_\_  
Has your child been evaluated for learning problems?  Yes  No
2. Does your child have any speech or language problems?  Yes  No  
If yes, explain: \_\_\_\_\_  
Has your child been evaluated by a Speech Language Pathologist?  Yes  No  
Is your child receiving speech therapy?  Yes  No  
How often? \_\_\_\_\_
3. Does your child have any known attention deficit or hyperactivity problems?  Yes  No  
If yes, explain: \_\_\_\_\_
4. Does your child have any known behavioral problems?  Yes  No  
If yes, explain: \_\_\_\_\_

**Listening and Understanding:**

- 1. Do you think your child has problems listening or understanding?  Yes  No  
If yes, explain: \_\_\_\_\_  
How long have you been aware of this problem? \_\_\_\_\_
- 2. Does your child have difficulties with any subjects at school?  Yes  No  
If yes, please list: \_\_\_\_\_  
What are your child's best subjects in school? \_\_\_\_\_
- 3. Does your child participate in any special class(es) or therapies?  Yes  No  
If yes, please describe: \_\_\_\_\_
- 4. Has your child been tutored?  Yes  No  
If yes, please describe: \_\_\_\_\_

**Behavior and Characteristics:**

Please check (✓) if your child exhibits any of the following behaviors or characteristics.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Extremely sensitive to loud sounds                     | <input type="checkbox"/> Daydreams                                 | <input type="checkbox"/> Lacks motivation                 |
| <input type="checkbox"/> Appears to be confused in noisy place                  | <input type="checkbox"/> Forgetful                                 | <input type="checkbox"/> Uncooperative                    |
| <input type="checkbox"/> Easily upset by new situations                         | <input type="checkbox"/> Often asks for repetition                 | <input type="checkbox"/> Disobedient                      |
| <input type="checkbox"/> Difficulties following and/or understanding TV program | <input type="checkbox"/> Reverses words, numbers, or letters       | <input type="checkbox"/> Destructive                      |
| <input type="checkbox"/> Difficulties following directions or instructions      | <input type="checkbox"/> Prefers to play with older children       | <input type="checkbox"/> Inappropriate social behavior    |
| <input type="checkbox"/> Does opposite of what is requested                     | <input type="checkbox"/> Prefers to play with younger children     | <input type="checkbox"/> Does not complete assignments    |
| <input type="checkbox"/> Restless; problem sitting still                        | <input type="checkbox"/> Prefers solitary activities               | <input type="checkbox"/> Easily frustrated                |
| <input type="checkbox"/> Overly active  | <input type="checkbox"/> Seeks attention                           | <input type="checkbox"/> Tires easily                     |
| <input type="checkbox"/> Short attention span                                   | <input type="checkbox"/> Disruptive or rowdy                       | <input type="checkbox"/> Irritable                        |
| <input type="checkbox"/> Impulsive  | <input type="checkbox"/> Temper tantrums                           | <input type="checkbox"/> Dislikes school                  |
| <input type="checkbox"/> Easily distracted                                      | <input type="checkbox"/> Shy                                       | <input type="checkbox"/> Fakes / exaggerates illness      |
| <input type="checkbox"/> Poor listener  | <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> Awkward / clumsy                 |
| <input type="checkbox"/> Says "what" or "huh"?                                  | <input type="checkbox"/> Lack self-confidence                      | <input type="checkbox"/> Depressed                        |
| <input type="checkbox"/> Difficulties recalling short or long term information  | <input type="checkbox"/> Reluctant to try new tasks                | <input type="checkbox"/> Uncoordinated or disorganized    |
| <input type="checkbox"/> Difficulties with time concept                         | <input type="checkbox"/> Give inappropriate responses to questions | <input type="checkbox"/> Difficulties reading and writing |