Pediatric Audiology Case History
Kireker Center for Child Development - Valley Hospital
505 Goffle Road    Ridgewood, NJ 07450
201-612-1006

Child’s Name: __________________________________________ Date of Birth: __________________ Age: ____________

Person Completing Form/Relationship: ____________________________________________________________________________

Who recommended this evaluation? ____________________________________________

Reason for evaluation: ____________________________________________________________

Developmental/Medical/Family History – Please indicate if your child has experienced any of the following:

_____ Premature Birth    _____ Mechanical Ventilation    _____ Serious Illness or Accidents
_____ Problems before, during, after Birth    _____ Head of Neck Abnormalities    _____ Ear Infections
_____ Hyperbilirubinemia/Jaundice    _____ Fetal Alcohol Syndrome    _____ Ear Tubes
_____ Bacterial Meningitis    _____ Delays in Development    _____ Allergies
_____ Congenital or Perinatal Infections    _____ Sensory Integration Issues    _____ Autism Spectrum Disorder
_____ Asphyxia/Lack of Oxygen at Birth    _____ Has a Syndrome    _____ ADHD
_____ NICU Stay of more than 5 Days    _____ Adopted/Foster Child – History Unknown
_____ Family History of Hearing Loss (Describe) __________________________________________
_____ Speech-Language Problems (Describe) ____________________________________________

_____ Known Hearing Problems:    _____ Right Ear    _____ Left Ear    _____ Both Ears
_____ Wears Hearing Aid(s):    _____ Right Ear    _____ Left Ear    _____ Both Ears

Previous Hearing Testing Completed at: ________________________________________________

Educational Information:    Grade: ________________ (Pre-)School: ___________________

Is your child classified? _____ No    _____ Yes    What educational classification? ________________________________

_____ 504 Accommodations? Please list services________________________________________

_____ IEP? Please list services______________________________________________________

Behaviors and Characteristics - Please indicate if your child exhibits any of the following:

_____ Sensitive to loud sounds    _____ Short attention span    _____ Forgetful
_____ Appears confused in noisy places    _____ Impulsive or Restless    _____ Asks for repetition; Says “Huh? Or What?”
_____ Easily upset in new situations    _____ Easily distracted    _____ Disruptive or Rowdy
_____ Difficulty following directions    _____ Daydreams    _____ Temper Tantrums
_____ Easily frustrated    _____ Tires easily    _____ Difficulty learning new concepts
_____ Reading problems    _____ Difficulty expressing ideas    _____ Difficulty with word meanings
_____ Spelling problems    _____ Problems with speech sound discrimination

Additional Information for the audiologist: ________________________________________________

__________________________________________________________________________________