

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Mechanical Ventilation | <input type="checkbox"/> Serious Illness or Accidents |
| <input type="checkbox"/> Problems before, during, after Birth | <input type="checkbox"/> Head of Neck Abnormalities | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Hyperbilirubinemia/Jaundice | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Ear Tubes |
| <input type="checkbox"/> Bacterial Meningitis | <input type="checkbox"/> Delays in Development | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Congenital or Perinatal Infections | <input type="checkbox"/> Sensory Integration Issues | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Asphyxia/Lack of Oxygen at Birth | <input type="checkbox"/> Has a Syndrome | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> NICU Stay of more than 5 Days | <input type="checkbox"/> 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:

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

Additional Information for the audiologist: _____

