THE AFA BALANCE & HEARING INSTITUTE
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AUDITORY PROCESSING DISORDER (APD) CASE HISTORY: CHILD

Adapted from APD Case History: Child by Eva M. Chiu, Au.D.

Patient Name: ______________________ **Age:**___ **Date of Birth:** ___ /___/___ **Today's Date:** ___/___/___

Person completing this form: ______________________ **Relationship to child:** ______________________

Referring Physician: ______________________

School: ______________________ **Grade:** ______________ **Teacher:** ______________________

Classroom Type: Traditional___ Open Podium___ Portable___ **Student's preferred hand:** Right___ Left___

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:

□ **Fetal alcohol syndrome**	□ **Ototoxic medication**	□ **Asphyxia**
□ **Hyperbilirubinemia**	□ **Mechanical Ventilation**	□ **Head/neck deformity**
□ **Bacterial Meningitis**	□ **Fever over 104° F**	□ **Craniofacial abnormalities**
□ **Congenital Perinatal infections**	□ **Maternal substance abuse**	□ **Syndromal abnormality**

OTOLOGICAL HISTORY:

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

   Please check all that apply:

   - ☐ Ear infections
   - ☐ Ear aches
   - ☐ Ear canal discharge
   - ☐ Excessive ear wax
   - ☐ Tubes in the ear
   - ☐ Hole/perforated eardrum
   - ☐ Fluid behind the ear
   - ☐ Soreness/pain in the ears
   - ☐ 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? ____________________________________

   What type? ____________________________________

   Was medication given? Yes No What? ____________________________________

4. Is there a family history of ear problems? Yes No

   If yes, who? ____________________________________

   What type? ____________________________________

   Was medication 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 medication given? ____________________________________

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. Has your child had any permanent hearing loss? Yes No

   If yes, describe: ____________________________________

   Has your child ever used amplification? ____________________________________

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: ______________________________

3. What are your child's best subjects in school? ______________________________

4. Does your child participate in any special class(es) or therapies? Yes No

   If yes, please describe: ______________________________

5. 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.

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

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Due to new HIPPA regulations ALL information must be filled out, otherwise we will not be able to process your claim and you will be billed for medical services.

PATIENT INFORMATION

LAST NAME: ______________________________ FIRST NAME: ______________________________

ADDRESS: ____

CITY: ______________________________ STATE: ____________________ ZIP CODE: __________

DATE OF BIRTH: ______________ SOCIAL SECURITY NUMBER: ________/______/________________

GENDER: MALE: ________ FEMALE: _______

PARENTS / GUARDIAN

MOTHERS NAME: ________________ DATE OF BIRTH: _____ SOCIAL SECURITY # ______/_____/_______

HOME PHONE #: ___________________________ CELL PHONE #: ___________________________

EMPLOYER: _______________________________ WORK PHONE # __________________________

ADDRESS: ____

FATHER'S NAME: ________________ DATE OF BIRTH: _______ SOCIAL SECURITY # ______/_____/______

HOME PHONE #: ___________________________ CELL PHONE #: ___________________________

EMPLOYER: _______________________________ WORK PHONE # __________________________

ADDRESS: ____

MAY WE LEAVE MESSAGES FOR YOUR AT THESE NUMBERS? ☐ YES ☐ NO
DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CHILD'S CARE ORTREATMENT WITH ANY PARTY (INCLUDING FAMILY MEMBERS BESIDE YOURSELF? IF YES, WITH WHOM? ___________________________________

REFERRING PHYSICIAN NAME: ____

CONTACT NUMBER: ____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: ____

POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT): ________________ DATE OF BIRTH: ___________

INSURANCE THROUGH EMPLOYER? ☐ YES ☐ NO (IF YES, EMPLOYER NAME: _____________________

INSURED ID #: ________________GROUP #: ____________ RELATIONSHIP TO PATIENT: ___________

SECONDARY INSURANCE CARRIER

POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT): ________________ DATE OF BIRTH: ___________

INSURANCE THROUGH EMPLOYER? ☐ YES ☐ NO IF YES, EMPLOYER NAME: _____________________

INSURED ID #: ______________ GROUP #: ______________ RELATIONSHIP TO PATIENT: ___________

Authorization to Release information and assignment of Benefits

I authorize payments of medical benefits to the provider for service rendered or to be rendered in the future without obtaining my signature on each claim submitted. I also authorize the release of any medical information necessary. I understand that I could be subject to a cancellation fee for each appointment missed where no notice is given or less than 24 hours of notice given. I am responsible for all charges regardless of insurance coverage. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand this office policy and procedure.

SIGNATURE: ______________________________ DATE: ________________________