THE AFA BALANCE & HEARING INSTITUTE
A.T. STILL UNIVERSITY OF HEALTH SCIENCES
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AUDITORY PROCESSING DISORDER (APD) CASE HISTORY: ADULT

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

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

Referring Physician: ________________________ **Physician Address:** ________________________________

HEARING HISTORY:

1. **Do you 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	□ Permanent hearing loss
□ Fluctuating hearing loss	□ Dizziness or Vertigo	□ Tinnitus (ringing in the ears)
□ Acoustic Neuromas/tumors	□ Cholesteatoma	□ Meniere's Disease
□ History of noise exposure	□ Otosclerosis	□ Sudden or progressive hearing loss
□ Collapsing ear canals	□ Ossicular dislocation/fixation	□ Labyrinthitis

2. **Have you had an ear infection in the last 6 months?** Yes No

   If yes, when? ____

   Was medication given? Yes No **What?** ______________________________

3. **Have you been treated by an Ear, Nose & Throat (ENT) doctor?** Yes No

   If yes, who? ____

   When? For What? ____

   Was medication given? Yes No **What?** ______________________________

4. **Have you ever had ear surgery?** Yes No

   If yes, describe: ____

   When? ____

5. **Is there a family history of ear problems or hearing loss?** Yes No

   If yes, who? ____

   What type? ____

6. **Have you previously had hearing tested by an Audiologist?** Yes No

   If yes, where and when? ____

   What were the results? ____

7. **Do you wear hearing aids?** **Yes** **No**

If yes, what kind? ______________________________

For which ear? □ **Right Ear** □ **Left Ear** □ **Both Ears**

Where did you get them? ____________________ **How old are they?** ____________________

Are there any problems with them? ______________________________

____

OTHER MEDICAL HISTORY:

1. **Are you currently taking any medication?** **Yes** **No**

   If yes, what? ______________________________

2. **Did you recently have a CT scan or MRI?** **Yes** **No**

   If yes, describe: ______________________________

   ____

Please check all that apply:

□ **Heart disease**	□ **Diabetes**	□ **High blood pressure**
□ **Stroke**	□ **Asthma**	□ **Meningitis**
□ **Mumps**	□ **Scarlet fever**	□ **Kidney or renal problems**
□ **Measles**	□ **Rubella**	□ **Influenza**
□ **Infectious disease:**___________	□ **Syphilis**	□ **Lyme diseases**
□ **Multiple Sclerosis**	□ **Autoimmune disease**	□ **Parkinson's**
□ **Head Trauma**	□ **Numbness in the face**	□ **Fever over 104 degrees**
□ **Cerebrovascular disorder**	□ **Facial nerve disorder**	□ **Herpes Zoster oticus**
□ **Tumors**	□ **Congenital disorder or disease:** ___________	□ **Ototoxic drug history**
		□ **Neurological disease:** ___________

LISTENING AND UNDERSTANDING:

1. **Do you feel you have problems listening or understanding?** **Yes** **No**

   If yes, explain: ______________________________

   How long have you been aware of this problem? ______________________________

2. **Do you have any known or documented learning problems?** **Yes** **No**

   If yes, explain: ______________________________

3. **Do you have any known or documented speech or language problems?** **Yes** **No**

   If yes, explain: ______________________________

4. **Do you have any known or documented attention deficit or hyperactivity problems?** **Yes** **No**

   If yes, explain: ______________________________

5. **Do you have any known or documented psychological problems?** **Yes** **No**

   If yes, describe: ______________________________

Please check any of the following that apply:

- ☐ **Extremely sensitive to loud sounds**
- ☐ **Cannot understand speech in noise**
- ☐ **Frequently misunderstood what is said**
- ☐ **Gets confused in noisy place**
- ☐ **Forgetful**
- ☐ **Has difficulty recalling spoken or written information**
- ☐ **Easily upset by new situations**
- ☐ **Often asks for repetition**
- ☐ **Difficulty following directions or instructions in series**
- ☐ **Difficulties following and understanding TV programs**
- ☐ **Reverses words, numbers, or letters**
- ☐ **Easily distracted**
- ☐ **Difficulties recalling short or long term information**
- ☐ **Give wrong or inappropriate responses to questions**
- ☐ **Uncoordinated or disorganized**
- ☐ **Does opposite of what is requested**
- ☐ **Prefers solitary activities**
- ☐ **Easily frustrated**
- ☐ **Restless; problem sitting still**
- ☐ **Depressed**
- ☐ **Has anxiety**
- ☐ **Irritable**
- ☐ **Lack motivation**
- ☐ **Easily tires**
- ☐ **Interprets words too literally**
- ☐ **ignores people, if engrossed**
- ☐ **Confused with similar sounding words**
- ☐ **Hears better when watching speaker**
- ☐ **Difficulties understanding rapid speech**
- ☐ **Miss important sounds or signals that others hear easily**
- ☐ **Difficulties memorizing things**
- ☐ **Difficulties localizing sounds**
- ☐ **Awkward/clumsy**
- ☐ **Difficulty writing**
- ☐ **Difficulties reading**
- ☐ **Difficulties with time concept**

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PATIENT INFORMATION

DUE TO HIPAA REGULATIONS **ALL** INFORMATION MUST BE FILLED OUT, OTHERWISE WE WILL NOT BE ABLE TO PROCESS YOUR CLAIM AND YOU MAY BE BILLED FOR MEDICAL SERVICES

LAST NAME :	FIRST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH : / /	SOCIAL SECURITY NUMBER: – –	
MARITAL STATUS: ❐ Single ❐ Married ❐ Widow/er ❐ Divorced ❐ Separated	GENDER ❐ M ❐ F	
HOME PHONE:	CELL PHONE:	
MAY WE LEAVE MESSAGES FOR YOU AT THESE NUMBERS? YES NO		

MISC CONTACT INFORMATION

EMERGENCY CONTACT NAME:	RELATIONSHIP:
HOME PHONE #:	CELL PHONE #:
DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CARE OR TREAMENT WITH ANY PARTY (INCLUDING FAMILY MEMBERS) BESIDE YOURSELF? **IF YES**, NAME/ PHONE NUMBER:	
REFERRING PHYSICIAN NAME:	PHONE NUMBER:

How did you hear about us?	❐ Yellow pages	❐ Friend	❐ Newspaper	❐ Doctor's Office	❐ Internet

EMPLOYMENT

EMPLOYMENT STATUS :	❐ FULL TIME	❐ PART TIME	❐ SELF EMPLOYED	❐ RETIRED	❐ STUDENT

OCCUPATION:	MAY WE CONTACT YOU AT WORK : ❐ Yes ❐ No		
EMPLOYER:	WORK PHONE # ( )		
WORK ADDRESS:	City	State	Zip Code

INSURANCE INFORMATION

***PRIMARY INSURANCE** CARRIER:*		
POLICY HOLDER NAME (IF DIFFERENT THAN PATIENT):		
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 :**