The Ear Center of Greensboro, P.A.
1126 N. Church Street, Suite 201
Greensboro, NC 27401
Phone: (336) 273-9932

AUDITORY PROCESSING: HISTORY

Name: ____

Date of Birth: __________ Chart number: __________.

General Information:

1. Sex ____ Male ______ Female
2. Age ____
3. Right Handed ____ Left Handed ______ Mixed Dominant _________.
4. Is this evaluation part of an overall educational or psychological evaluation?
   ____ No ____ Yes. If yes, who else has evaluated this child? ___________________
5. Who referred you to our office for this evaluation? ___________________________
6. Besides yourself, who should receive copies of our report from today? (Please provide addresses) ____
____

Educational Information

1. This child is in the _________ grade.
2. What school does this child attend? _____________________________________
3. Does your child like school? ___No ___ Yes.
4. This child's school performance is:
   ______excellent _____above average _____ average _____ below average ____ poor
5. Has your child ever repeated a grade? ___ No ___ Yes. If yes, what grade and why?
   ____
6. Does this child receive special assistance in school (i.e. remedial reading, resource room, speech therapy, etc.)? ___ No ___ Yes. If yes, please explain. _______________
   ____
7. Is this child better at some subjects than others? ___ No ___ Yes. If yes, describe
   stronger? ____
   weaker? ____
8. Does this child have difficulty with: Phonics ___ No ___ Yes
   Spelling ___ No ___ Yes
   Reading Mechanics ___ No ___ Yes
   Reading Comprehension ___ No ___ Yes

9. Do you think your child has a language problem (i.e. understanding language, formulating thoughts into words, using appropriate language, etc.)? ___ No ___Yes. If yes, please explain. ______________________________

10. How would you rate your child's vocabulary?
_____ Excellent _____ Good ____ Fair ____ Poor

11. Does your child have a diagnosis of any of the following:
Learning disability ___ No ___ Yes. If yes explain. ______________________________
____
Mental delays ___ No ___ Yes. If yes explain. ______________________________
____
Speech/Language disorder ___No ___ Yes. If yes explain. ______________________________
____
(If you answered yes to any of the questions in #11, the AP evaluation may not offer conclusive results for your child. Some deficits, which are basic processing problems, interfere with accurate testing on auditory processing testing.)

Medical History

1. Describe any problems or concerns during your pregnancy with your child. ________
____
____
2. What was the length of pregnancy? ______________________________
3. What was your child's birth weight? ______________________________
4. Describe any complications or concerns during the birthing process. ______________
____
5. Has your child had a history of ear infections? ___ No ___ Yes.
If yes, how many per year? _______ When was the last infection? ________________
6. Has your child had ear tubes or surgery to treat these infections or ear disease? ____
If yes, when and what? ______________________________
7. Has your child ever had a documented hearing loss? ___ No ___ Yes. If yes, explain the type of loss to the best of your knowledge. ______________________________
8. Has your child had a serious head injury ? ___ No ___ Yes. If yes, explain. ________
____
9. Is there a history of family hearing loss? ___ No ___ Yes. If yes, list who and any details that you know. ______________________________
10. Have any immediate family members been diagnosed with an AP disorder?
___ No ___ Yes. If yes, explain. ______________________________
11. Did your child reach developmental milestones on schedule? __ No ___ Yes. If no, explain. ______________________________
12. Please list all childhood diseases. ______________________________
____

Symptoms

1. What behaviors or symptoms make you suspect that your child may have an auditory processing disorder? ____
____

2. Does your child express difficulty hearing? __ No ___ Yes.
3. Does your child say “huh” or “what” frequently? __ No ___ Yes.
4. Can your child remember multiple instructions/sequential commands? __ No___ Yes.
5. Do you often repeat directions to your child? __ No ___ Yes.
6. Does your child forget what is said in a few minutes? ___ No ___ Yes.
7. Does your child often misunderstand what is said? ___ No ___ Yes.
8. Does your child confuse similar words or sounds? ___ No ___ Yes.
9. Is your child easily distracted by background sounds? ___ No ___ Yes.
10. Does your child have a short attention span? ___ No ___ Yes.
11. Does your child appear to daydream or show lack of motivation? ___ No ___ Yes.
12. Is your child easily frustrated? ___ No ___ Yes.
13. Would you consider your child hyperactive? ___ No ___ Yes.

14. Your child has motor and coordination skills which are:
___ Excellent ___ Average ___ Fair ___ Poor
15. Does your child have any behavior problems at home or in the classroom?
__ No ___ Yes. If yes, explain. ____
____
16. How would you describe the nature or personality of your child? ________________
____
17. Has your child been diagnosed with an attention deficit disorder? __ No ___ Yes.
If yes, explain, when? ________. What physician does he/she see?_____________
Any medication prescribed for this problem? ______________________________
What is the dosage of medication and how often taken? _____________________
How long has he/she been on this medication?____________________________
What are the results of this medication? _________________________________
18. Is there any other information that you think would be beneficial for us to know? ___
____
____

AP TEST RESULTS WILL NOT BE AVAILABLE ON THE DAY OF THE EVALUATION AS IT TAKES TIME TO ANALYZE THE TEST RESULTS. YOU WILL RECEIVE A WRITTEN REPORT IN 7-10 DAYS WHICH WILL EXPLAIN THE TESTS, HOW YOUR CHILD PERFORMED, AND PROVIDE YOU WITH RECOMMENDATIONS WHICH MAY BE HELPFUL IN SCHOLL AND AT HOME. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT OUR AUDIOLOGY DEPARTMENT AT (336) 273-9932