

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

Case History  
Page 2

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 SCHOOL AND AT HOME. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT OUR AUDIOLOGY DEPARTMENT AT (336) 273-9932