Allergy Ear Nose & Throat INSTITUTE
EXCELLENCE SINCE 1992
"To God be the Glory"

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ADULT CENTRAL AUDITORY PROCESSING QUESTIONNAIRE

Name:	Age:	Date of Birth:	Gender: M / F
Referred By:	Occupation:		Date:

Please <u>check all</u> that apply to you. When asked, please *describe* the details.

MEDICAL HISTORY

☐ Measles	☐ Mumps	☐ Hole in the Eardrum(s)
☐ Head Trauma	☐ IV Antibiotics	☐ Ear Surgery
☐ Ear Pain	☐ Ear Drainage	☐ Noise Exposure (occupational or recreational)
☐ Middle Ear Fluid	☐ Head Trauma	☐ Work around Chemicals
☐ Hearing Loss	☐ Ringing in Ears	☐ Attention Deficit / Hyperactivity Disorder (AD/HS)
☐ Dizziness	☐ Wear Hearing Aids	☐ Impaired Vision

☐ Meningitis: *If yes, what type?* ☐ Bacterial ☐ Viral *Dates:*

☐ Family History of Hearing Loss or Hearing Difficulties?

If yes, who has these problems? ☐ Mother ☐ Father ☐ Sibling ☐ Uncle ☐ Aunt ☐ Grandparent

☐ Chronic Ear Infections. *If yes, total number and most recent episode:*

☐ Previous evaluation by an ENT (ear, nose, & throat) physician? *If yes, whom?*

Physician Name: *City, State:*

Previous Hearing Test: ☐ No ☐ Yes *Location:* *Date:*

Results: ☐ Normal ☐ Permanent Hearing loss ☐ Temporary Hearing Loss

Right / Left / Both *Right / Left / Both* *Right / Left / Both*

Current Primary Physician: *City, State:*

EDUCATIONAL HISTORY

Have you ever repeated a grade? ☐ No ☐ Yes. *If yes, which one?*

Your Favorite Subject in School:

Your Least Favorite Subject in School:

Academic Performance: ☐ As & Bs ☐ Bs & Cs ☐ Cs& Ds ☐ Failing ☐ Mixture A - F

Received Tutoring: ☐ No ☐ Yes. *If yes, please describe:*

Did you have difficulty completing assignments: ☐ No ☐ Yes. *If yes, please describe:*

Have difficulty with: ☐ Spelling ☐ Reading ☐ Writing ☐ Speaking ☐ Math ☐ Music

Diagnosed with: ☐ Dyslexia ☐ Learning Disorder ☐ Autism
☐ Speech / Language Disorder ☐ Sensory Integration problem

Family History of: ☐ Dyslexia ☐ Learning Disorder ☐ Autism
If yes, who has these problems? ☐ Mother ☐ Father ☐ Sibling ☐ Uncle ☐ Aunt ☐ Grandparent

BEHAVIORAL / SOCIAL: Check those that apply to you.

☐ Easily Frustrated	☐ Unorganized / "Messy"	☐ Forgetful
☐ Uncoordinated	☐ Enjoy Playing Sports	☐ Enjoy Singing / Playing Music
☐ Make Friends Easily	☐ Short Attention Span	☐ Prefer Solitary Activities
☐ Low Self-Esteem	☐ Shy	☐ Overly Active
☐ Trouble Sitting Still	☐ Impulsive	☐ Lack Self-Motivation
☐ Daydreams	☐ Destructive	☐ Forgetful
☐ Difficulty Sleeping	☐ Inappropriate Social Behavior	

☐ Easily Distracted by ☐ *Sounds* ☐ *Sights* ☐ *Touch*

HEARING & LISTENING: Check those that apply to you.

☐ Noise exposure. *If yes, please describe:*

☐ Use of hearing protection in loud noise	☐ Seem to hear but not understand
☐ Often ask "huh?" or "what?"	☐ Ask for speakers to repeat themselves
☐ Talk loudly	☐ Listen to TV / radio at high volume
☐ Sensitive to average or loud sounds	☐ Startle to loud sounds
☐ Difficulty hearing in noise	☐ Difficulty following multi-stage verbal directions
☐ Reverse numbers / letters	☐ Do opposite of what is asked of him/her
☐ Difficulty remembering what is heard	☐ Trouble determining location of sounds
☐ Misunderstand rapid / muffled speech	☐ Difficulty discriminating speech sounds

Please provide any other information that you think may be useful in helping us understand your hearing and listening difficulties: