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PEDIATRIC CENTRAL AUDITORY PROCESSING QUESTIONNAIRE

Name:	Age:	Date of Birth:	Gender: M / F
Parent(s):	Referred By:		Date:
School:	Grade:	Teacher:	
School Room Setting: ☐ Traditional	☐ Open	☐ Portable	

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

MEDICAL HISTORY		
☐ Jaundice	☐ Measles	☐ Mumps
☐ CMV	☐ Head Trauma	☐ IV Antibiotics
☐ Ear Pain	☐ Ear Drainage	☐ Hole in the Eardrum(s)
☐ Middle Ear Fluid	☐ Patched Eardrum Hole	☐ Pressure (Ear) Tubes
☐ Hearing Loss	☐ Ringing in Ears	☐ Attention Deficit / Hyperactivity Disorder (AD/HS)
☐ Allergies	☐ Dizziness	☐ Sinus or Upper Respiratory Infections

☐ 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:*

Current Medications:

DEVELOPMENTAL HISTORY			
☐ Pregnancy Complications			
☐ Before Birth. *Please describe:*			
☐ During Birth. *Please describe:*			
☐ Premature Birth *If yes, how early?*			
☐ Low Birth Weight *If yes, what was weight?*			
☐ Low Apgar Score	☐ Meconium Poisoning	☐ Received (Mechanical) Oxygen	
☐ Speech or Language Delay	☐ Motor Developmental Delay		
☐ Receives Therapy: *(what kind?)*	☐ Speech / Language	☐ Occupational	☐ Physical
Other:			

EDUCATIONAL HISTORY
Has your child repeated a grade? ☐ No ☐ Yes. *If yes, which one?*
Child's Favorite Subject:
Child's Least Favorite Subject:
Academic Performance: ☐ As & Bs ☐ Bs & Cs ☐ Cs& Ds ☐ Failing ☐ Mixture A - F
Receives Tutoring: ☐ No ☐ Yes. *If yes, please describe:*
Has difficulty completing assignments: ☐ No ☐ Yes. *If yes, please describe:*
Has 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		
☐ Easily Frustrated	☐ Unorganized / "Messy"	☐ Forgetful
☐ Uncoordinated	☐ Enjoys Playing Sports	☐ Enjoys Singing / Playing Music
☐ Makes Friends Easily	☐ Short Attention Span	☐ Prefers Solitary Activities
☐ Low Self-Esteem	☐ Shy	☐ Overly Active
☐ Trouble Sitting Still	☐ Impulsive	☐ Lacks Self-Motivation
☐ Daydreams	☐ Destructive	☐ Forgetful
☐ Difficulty Sleeping	☐ Inappropriate Social Behavior	
☐ Easily Distracted by:	☐ Sounds ☐ Sights	☐ Touch

HEARING & LISTENING

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

☐ Use of hearing protection in loud noise	☐ Seems to hear but not understand
☐ Often asks “huh?” or “what?”	☐ Asks for speakers to repeat themselves
☐ Talks loudly	☐ Listens to TV / radio at high volume
☐ Sensitive to average or loud sounds	☐ Startles to loud sounds
☐ Difficulty hearing in noise	☐ Difficulty following multi-stage verbal directions
☐ Reverses numbers / letters	☐ Does opposite of what is asked of him/her
☐ Difficulty remembering what is heard	☐ Trouble determining location of sounds
☐ Misunderstands rapid / muffled speech	☐ Difficulty discriminating speech sounds

Do **you** think your child has a problem with listening or understanding? ☐ No ☐ Yes

If yes, please describe examples:

Does your **child’s teacher** think your child has a problem with listening or understanding?

☐ No ☐ Yes

If yes, please describe examples:

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