### ADULT CENTRAL AUDITORY PROCESSING QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Date of Birth:</th>
<th>Gender: M / F</th>
</tr>
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<tbody>
<tr>
<td>Referred By:</td>
<td>Occupation:</td>
<td>Date:</td>
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Please check all 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:*

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<tr>
<th>Have difficulty with:</th>
<th>□ Spelling</th>
<th>□ Reading</th>
<th>□ Writing</th>
<th>□ Speaking</th>
<th>□ Math</th>
<th>□ Music</th>
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Diagnosed with:  □ Dyslexia  □ Learning Disorder  □ Autism  □ Speech / Language Disorder  □ Sensory Integration problem

Family History of:  □ Dyslexia  □ Learning Disorder  □ Autism  □ Speech / Language Disorder  □ Sensory Integration problem  
*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: