PEDiATRIC CENTRAL AUDiTORY PROCESSING QUESTIONNAiRE

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Date of Birth:</th>
<th>Gender: M / F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent(s):</td>
<td>Referred By:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Teacher:</td>
<td></td>
</tr>
<tr>
<td>School Room Setting:</td>
<td>Traditional</td>
<td>Open</td>
<td>Portable</td>
</tr>
</tbody>
</table>

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

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