



4920 SW Lee Blvd, Lawton, OK 73505 (580) 536-8844
1015 E. Broadway, Ste. 103, Altus, OK 73521 (580) 477-1033

PEDIATRIC CENTRAL AUDITORY PROCESSING QUESTIONNAIRE

Name:	Age:	Date of Birth:	Gender: M / F
Parent(s):	Referred By:	Date:	
School:	Grade:	Teacher:	
School Room Setting:	<input type="checkbox"/> Traditional	<input type="checkbox"/> Open	<input type="checkbox"/> Portable

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

MEDICAL HISTORY			
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	
<input type="checkbox"/> CMV	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> IV Antibiotics	
<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Ear Drainage	<input type="checkbox"/> Hole in the Eardrum(s)	
<input type="checkbox"/> Middle Ear Fluid	<input type="checkbox"/> Patched Eardrum Hole	<input type="checkbox"/> Pressure (Ear) Tubes	
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Attention Deficit / Hyperactivity Disorder (AD/HS)	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sinus or Upper Respiratory Infections	
<input type="checkbox"/> Meningitis: <i>If yes, what type?</i> <input type="checkbox"/> Bacterial <input type="checkbox"/> Viral <i>Dates:</i>			
<input type="checkbox"/> Family History of Hearing Loss or Hearing Difficulties? <i>If yes, who has these problems?</i> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Grandparent			
<input type="checkbox"/> Chronic Ear Infections. <i>If yes, total number and most recent episode:</i>			
<input type="checkbox"/> Previous evaluation by an ENT (ear, nose, & throat) physician? <i>If yes, whom?</i> <i>Physician Name:</i> _____ <i>City, State:</i> _____			
Previous Hearing Test: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Location:</i> _____ <i>Date:</i> _____			
Results: <input type="checkbox"/> Normal <input type="checkbox"/> Permanent Hearing loss <input type="checkbox"/> Temporary Hearing Loss <i>Right / Left / Both</i> <i>Right / Left / Both</i> <i>Right / Left / Both</i>			
Current Primary Physician:		<i>City, State:</i> _____	
Current Medications:			

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

EDUCATIONAL HISTORY		
Has your child repeated a grade? <input type="checkbox"/> No <input type="checkbox"/> Yes. <i>If yes, which one?</i>		
Child's Favorite Subject:		
Child's Least Favorite Subject:		
Academic Performance:	<input type="checkbox"/> As & Bs	<input type="checkbox"/> Bs & Cs <input type="checkbox"/> Cs& Ds <input type="checkbox"/> Failing <input type="checkbox"/> Mixture A - F
Receives Tutoring: <input type="checkbox"/> No <input type="checkbox"/> Yes. <i>If yes, please describe:</i>		
Has difficulty completing assignments: <input type="checkbox"/> No <input type="checkbox"/> Yes. <i>If yes, please describe:</i>		
Has Difficulty with: <input type="checkbox"/> Spelling <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Speaking <input type="checkbox"/> Math <input type="checkbox"/> Music		
Diagnosed with: <input type="checkbox"/> Dyslexia <input type="checkbox"/> Learning Disorder <input type="checkbox"/> Autism		
<input type="checkbox"/> Speech / Language Disorder <input type="checkbox"/> Sensory Integration problem		
Family History of: <input type="checkbox"/> Dyslexia <input type="checkbox"/> Learning Disorder <input type="checkbox"/> Autism		
<i>If yes, who has these problems?</i> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Grandparent		

BEHAVIORAL / SOCIAL		
<input type="checkbox"/> Easily Frustrated	<input type="checkbox"/> Unorganized / "Messy"	<input type="checkbox"/> Forgetful
<input type="checkbox"/> Uncoordinated	<input type="checkbox"/> Enjoys Playing Sports	<input type="checkbox"/> Enjoys Singing / Playing Music
<input type="checkbox"/> Makes Friends Easily	<input type="checkbox"/> Short Attention Span	<input type="checkbox"/> Prefers Solitary Activities
<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Shy	<input type="checkbox"/> Overly Active
<input type="checkbox"/> Trouble Sitting Still	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Lacks Self-Motivation
<input type="checkbox"/> Daydreams	<input type="checkbox"/> Destructive	<input type="checkbox"/> Forgetful
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Inappropriate Social Behavior	
<input type="checkbox"/> Easily Distracted by:	<input type="checkbox"/> Sounds	<input type="checkbox"/> Sights <input type="checkbox"/> Touch

HEARING & LISTENING

Noise exposure. *If yes, please describe:*

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