Pediatric Audiological History Form

St. John's University
SPEECH & HEARING CENTER
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Flushing, NY 11367
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Mailing Address:
St. John's University
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8000 Utopia Parkway
Queens, NY 11439

Name _____ Phone # _____ Cell # _____Date_____

Address_____ Informant _____

City _____ State _____ Zip_____

Date of Birth _____ / _____ / _____ Present Age _____

Father's Name _____ Occupation _____ Work Ph.# _____

Mother's Name _____ Occupation _____ Work Ph.# _____

Sibling's Name & Age _____

Referred by _____ Date of Evaluation _____ / _____ / _____

What is your child's first language? _____

What is the primary language spoken in the home?_____

DESCRIPTION OF PROBLEM

Briefly describe problem _____

_____

When wasit first noticed? _____

What was done about it? _____

SPEECH & HEARING DEVELOPMENT

Does child respond to sound? _____

Does child respond to spoken directions and questions? _____

Does child appear to hear adequately? _____

Does child appear to be developing speech & language normally?_____

_____

How many words does your child have in his/her vocabulary? _____

Does your child put words together? _____If yes, 2-3_____/or more_____ **(check one)**

Does any family member (including aunts, uncles, grandparents) have a hearing and /or speech impairment?

_____

Does your child wear a hearing aid? If yes, make _____ model_____

Right _____Left _____Binaural_____

Referred by _____ When? _____

LABOR, PREGNANCY & DELIVERY

Did mother have any accidents, illness, or other unusual conditions such as Rh negative during pregnancy?

If yes, explain in detail_____

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Did mother have 9 month pregnancy with child? _____

Was labor, delivery and development normal? If no, please explain _____

_____

Were there any problems at birth? If yes, please explain_____

_____

Apgar Score was 1 2 3 4 5 6 7 8 9 10 **(Circle one)**

Was the child "blue" or "yellow" at birth? _____

Was light therapy utilized?_____

Were there any drugs used? _____

Did child pass newborn hearing screening? Yes_____ No _____

At what age did child hold head erect _____ Walk unaided_____

Become toilet trained _____ say first words _____

MEDICAL HISTORY

Did your child have immunization for childhood diseases? (i.e. measles, mumps, chicken pox). If not, did he/she have any of those listed or any other?_____

_____

Does child have chronic colds, allergies, sore throats or tonsil and adenoid problems? If yes, please circle.

Has your child had ear infections? If yes, how many and when was the last one? Please describe treatment.

_____

Does your child take any medication? _____ If yes, name and dose_____

Has your child been hospitalized? If yes, why, when, where? _____

_____

Does your child have sleep problems (i.e. snoring, apnea)? _____

EDUCATIONAL HISTORY

Does your child attend school?_____ If yes, where?_____
What grade?_____
Does your child have an IEP?_____Classification_____
What special services does your child receive?_____

Circle all that apply

Speech/language_____	group/individual
OT_____	group/individual
PT_____	group/individual
ABA_____	group/individual
Counseling_____	group/individual

What is the student/teacher ratio?_____

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