SOUTHBURY AUDIOLOGY | Cathleen A. Alex, Au.D. Stephanie Bakewell, Au.D.

Pediatric Case History

Identifying and Family Information

Patient Information:			
Child's Name:	Date of Birth:	Age:	Gender: ☐M ☐F
Street Address:	Town:	State:	Zipcode:
Primary Phone:	School:		Grade:
Who referred you to our practice?	Pediatrician:		
What is your main concern for today's visit?			

Guardian/Family Information:		
Parent/Guardian:	Relationship:	Cell Phone:
Email:	Occupation:	
Parent/Guardian:	Relationship:	Cell Phone:
Email:	Occupation:	
Child lives with: ☐ Birth Parents ☐One Parent ☐Foster Parent ☐Adoptive Parent ☐Parent and Step-Parent ☐Other: _____		
Other children in the Home? ☐ No ☐ Yes Name: Age: Gender: Grade: Speech/Hearing Concerns?		
Is there another language besides English spoken in the home? ☐ No ☐ Yes, Language?		

Insurance Information:	
Primary Insurance Company:	Policy Holder's Name:
Policy Holder's Relationship to child:	Policy Holder's Date of Birth:
Secondary Insurance Company:	Policy Holder's Name:
Policy Holder's Relationship to child:	Policy Holder's Date of Birth:
I authorize payment of medical benefits to Southbury Audiology, LLC for services rendered. I also authorize the release of any medical information to process this claim. I understand that I am responsible for any co-pays, deductibles, or uninsured expenses.	
Signed:	**Date:**
Print:	**Relationship to Child:**

Hearing History

Did the child pass the newborn hearing screening?	☐Yes ☐ No
In which Hospital: Follow up:	
When was the child's last hearing screening or evaluation? Date:	
By whom: Results:	
Does the child have a history of ear infections?	☐ Yes ☐ No
Treated By: ☐ PEDI ☐ ENT Treated with: ☐ Antibiotics ☐Tubes (____# of sets)	
Has the child ever been diagnosed with a hearing loss?	☐ Yes ☐ No
Please Explain:	
Has the child ever been fit with a hearing aid?	☐ Yes ☐ No
Please Explain:	
Has the child ever been evaluated for auditory processing?	☐ Yes ☐ No

Birth History

Prematurity: ☐ No ☐ Yes NICU Stay: ☐ No ☐ Yes How Long? Gestational Age:

Jaundice/Hyperbilirubinemia: ☐ No ☐ Yes Treatment: Birth weight:

Complications during pregnancy/delivery:

Perinatal infections: ☐ Cytomegalovirus ☐Rubella ☐Herpes ☐Toxoplasmosis ☐ Syphilis

Medical attention following birth:

☐Blood transfusion ☐Medications ☐Cleft Palate ☐Craniofacial Anomalies ☐Lack of Oxygen
Please Explain:

Did any family member smoke cigarettes in the household during pregnancy? ☐ Yes ☐ No

Developmental History

Did/does the child have delayed speech/language development? ☐Yes ☐No
Explain:

Did/does the child have delayed motor development? ☐Yes ☐No
Explain:

Did/does the child have Sensory issues? ☐Yes ☐No
Explain:

Did/does the child receive Intervention Services? ☐Yes ☐ No
☐Speech Therapy ☐Occupational Therapy ☐ Physical Therapy ☐ Sensory Integration ☐ Other
Explain:

Health History

Is the child currently in good health? ☐Yes ☐No

Has the child ever complained of any of the following?

☐Trouble Hearing	☐Ear Pain	☐ Ear Pressure
☐Ear Popping	☐Ringing in the Ears	☐Dizziness

Has the child ever been diagnosed or present with any of the following?

☐ Head trauma/injury	☐ Visual problems	☐Diabetes
☐ Seizure Disorder	☐ ADHD/ADD/Attention difficulties	☐ Anxiety and/or Depression
☐ Autism/PDD/Asperger's Disorder	☐ Learning Disability	☐ Language Disorder
☐ Articulation Disorder	☐ Headaches	☐ Sinus Issues
☐ Frequent Colds/Congestion	☐ Allergies	☐ Bacterial Meningitis
☐ Syndrome: _____	☐Other_____	

Family History

Have any members of the child's family ever been diagnosed with:

	Mother	Father	Sibling	Grandparent
Seizure Disorder	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Anxiety/Depression	☐	☐	☐	☐
Autism/PDD/Asperger's	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐
Language Disorder	☐	☐	☐	☐
Articulation Disorder	☐	☐	☐	☐
Childhood Hearing Loss	☐	☐	☐	☐
Early Adult Hearing Loss	☐	☐	☐	☐
Auditory Processing	☐	☐	☐	☐
Dyslexia	☐	☐	☐	☐
Genetic Syndrome	☐	☐	☐	☐

Please list any other important family history here: