Pediatric Audiology Intake

Identifying and Family Information

Child's Name: _____ Date of Birth: _____ Age: ___ Gender: ☐M ☐F

Street Address: _____ Town:_____ State:___ Zipcode:_____
School: _____ Grade: _____

Parent/Guardian: _____ Relationship: _____
Email: _____ Telephone : _____
Cell Phone: _____ Occupation: _____

Parent/Guardian: _____ Relationship: _____
Email: _____ Telephone : _____
Cell Phone: _____ Occupation: _____

Person completing form: _____ Relationship to Child:_____

Please present insurance cards to receptionist for photocopy

Primary Insurance Co._____Secondary Ins. Co._____
Who referred you to our practice? _____ Primary Care Physician:_____

I authorize payment of medical benefits to Cathleen A. Alex, Au.D., 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**_____
Relationship to patient: _____

Child lives with (check one)

☐ Birth Parents ☐Foster Parents ☐One Parent ☐Adoptive Parents ☐Parent and Step-Parent
☐Other: _____

Other Children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Is there a language other than English spoken in the home? ☐ Yes ☐ No
If so, which language? _____

Hearing History

Please explain reason for referral and concerns you have about the child's hearing:

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 had an auditory processing evaluation? ☐ Yes ☐ No By whom: Results:

Birth History

Prematurity: ☐ Yes ☐ No Gestational Age at Birth: weeks

Jaundice: ☐Yes ☐ No

Complications during pregnancy/delivery:

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 Explain:

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 Early Intervention Services? ☐Yes ☐ No
☐Speech Therapy ☐OT ☐ PT ☐ Sensory Integration ☐ Play Group

Medical History

Does the child present with any of the following medical conditions?
☐Head trauma/injury ☐ Ear infection ☐Visual problems ☐Syndrome _____
☐Other_____

Does the child have any of the following diagnoses?
☐ Seizure Disorder ☐ADHD/ADD/Attention difficulties ☐ Anxiety and/or Depression
☐ Autism/PDD/Asperger's Disorder ☐ Learning Disability ☐ Language Disorder
☐Articulation Disorder ☐ Hearing Loss

Does the child currently take any medications? ☐Yes ☐No
List:

Does the child currently receive any outpatient therapy services?
☐Speech/Language ☐OT ☐PT ☐SI ☐ Other:

Family History

Does any family member have any of the following diagnoses:		Mother	Father	Sibling
	Seizure Disorder	☐	☐	☐
	ADHD/ADD	☐	☐	☐
	Anxiety/Depression	☐	☐	☐
	Autism/PDD/Asperger's	☐	☐	☐
	Learning Disability	☐	☐	☐
	Language Disorder	☐	☐	☐
	Articulation Disorder	☐	☐	☐
	Hearing Loss	☐	☐	☐
	Auditory Processing	☐	☐	☐
	Dyslexia	☐	☐	☐
	Genetic Syndromes	☐	☐	☐
Please list any other important family history here:				