PEDIATRIC BACKGROUND INFORMATION

Appt. Date: _____

Child's Name:_____ Birth Date:_____Age:_____

Parents' Names: Mother:_____ Father:_____

Siblings (sex and age):_____

Referred by: _____ Child's Physician:_____

Why are you bringing your child to see us?_____

_____

Do you think your child has a hearing problem? _____ If yes, please explain_____

_____

How does your child function in a playgroup, preschool, or school environment? Are there any social or learning issues you or your child's teacher are concerned about?_____

_____

Is your child in an early intervention program? If yes, Where? What therapy? How often?

_____

_____

Please list support services your child is receiving, if any:_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

Allergies:_____

Ear Infections:_____ If yes a) Treatment_____

b)Approximately how many per year_____

c)Approximate date of last ear infection_____

Myringotomy and/or ventilating tubes_____ Date:_____ Which ear?_____

High fevers_____ If yes, explain_____

Frequent colds_____ Serious illnesses_____

Is there a history of hearing loss in either parent's family?_____

Has your child ever been examined by any of the following? If so, when and why?

Ear, Nose and Throat Physician_____

Neurologist_____

Audiologist_____

Speech and Language Pathologist_____

<u>BIRTH HISTORY</u>:

Was pregnancy with this child full term?_____

Did mother have any illnesses during pregnancy?_____

Please list medications taken during pregnancy:_____

Other Complications?_____

Were there any complications with birth or delivery?_____

DEVELOPMENTAL MILESTONES:

At what age did the child do the following? (give approximate age)

Held head up_____Sat alone_____ Rolled over_____Crawled_____

Walked independently_____

Do you feel the child's coordination is the same as other children his/her age?_____

SPEECH AND HEARING HISTORY:

As a baby, did the child respond to sounds even when he/she could not see the source of the sound?____

Respond to speech?_____ Startle to loud sounds?_____

Did your child babble and coo as much as most babies?_____Did he/she cry excessively?_____

Was the child a very quiet baby?_____

Does your child consistently respond to sound and speech now?_____

Do loud sounds appear to really bother your child? _____

Does your child appear to have an ear preference?_____ Which one?_____

How old was the child when he/she began to say words?_____ When he/she began to put 2 or 3 words together in a phrase?_____ When he/she began to use complete sentences?_____

Did he/she acquire speech and then stop talking?_____

Does the child engage in conversation?_____

Does the child use gestures to express needs and wants?_____

Does the child use language to express needs and wants?_____ How often?_____

Do parents understand his/her speech?_____ Do other adults understand him/her?_____

Do playmates tease the child about his/her speech?_____

Is the child's voice too soft? ____ Too loud?____ Hoarse?____ Nasal?____

Have parents done anything to help the child with speech/language?_____ Explain:_____

_____

Is the child's vocabulary similar to other children his/her age?_____

PLEASE WRITE ANY OTHER ADDITIONAL INFORMATION YOU FEEL WOULD BE HELPFUL FOR US TO KNOW ABOUT YOUR CHILD _____

_____

_____