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## AUDITORY PROCESSING DISORDERS CASE HISTORY

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Child's preferred hand (circle) Right Left Both Physician \_\_\_\_\_

Form completed by (name and relationship) \_\_\_\_\_

### Otologic History

*(Ear problem includes: ear infection, earaches, draining ears, medicine taken for an ear problem, doctor noticed fluid behind the eardrum, hole in eardrum, etc.)*

How many ear problems has your child had? (circle)

None 1-2 3-5 6-10 10 or more

Has your child had an ear problem in the last 6 months? (circle) Yes No

If yes, when? \_\_\_\_\_ What type of ear problem? \_\_\_\_\_

Was medication given? Yes No What medication was given? \_\_\_\_\_

Does your child have any of the following? (circle)

Frequent runny nose Ringing or buzzing in the ear

Frequent colds or sinus infections Dizziness

Allergies

Has anyone related to the child had any ear problems? (circle) Yes No

Who? \_\_\_\_\_

What type of ear problem? \_\_\_\_\_

Has your child ever been seen by and Ear, Nose, & Throat (ENT) doctor? (circle) Yes No

If yes, which doctor? \_\_\_\_\_ When? \_\_\_\_\_

Has your child ever had any ear surgery? (circle) Yes No

If yes, describe \_\_\_\_\_

Has your child previously had his / her hearing tested by an audiologist?

If yes, which audiologist? \_\_\_\_\_ When? \_\_\_\_\_

What were the results? \_\_\_\_\_

Does your child have any permanent hearing loss? Yes No

If yes, describe \_\_\_\_\_

Has your child ever used amplification? Yes No

**Family History**

Is there a family history of learning problems? Yes No

If yes, explain \_\_\_\_\_  
 \_\_\_\_\_

**Developmental History**

Were there any complications during or after your child's birth? Yes No

If yes, explain \_\_\_\_\_  
 \_\_\_\_\_

Were there any delays in your child's development? Yes No

If yes, explain \_\_\_\_\_  
 \_\_\_\_\_

Has your child had any serious illnesses or accidents? Yes No

\_\_\_\_\_  
 \_\_\_\_\_

Does your child take any medications? Yes No

If yes, please list \_\_\_\_\_

**Listening and Understanding**

Do you think your child has a problem listening or understanding? Yes No

If yes, give examples \_\_\_\_\_  
 \_\_\_\_\_

Does your child have difficulty with any subjects at school? Yes No

If yes, please list \_\_\_\_\_

What are your child's best subjects in school? \_\_\_\_\_

Does your child participate in any special classes or therapies? Yes No

If yes, describe \_\_\_\_\_  
 \_\_\_\_\_

Has your child been tutored? Yes No

If yes, describe \_\_\_\_\_

How does your child perform on musical activities? \_\_\_\_\_  
 \_\_\_\_\_

