Center for Hearing and Communication
Connect to Life™

50 Broadway, 6th Floor
New York, NY 10004
(917) 305-7700 (Voice)
(917) 305-7888 (Fax)

2900 W. Cypress Creek Rd.
Ft. Lauderdale, FL 33309
(954) 601-1930 (Voice)
(954) 601-1399 (Fax)

CHILDREN'S DIAGNOSTIC QUESTIONNAIRE

Today's Date _____ Child's Social Security # _____

IDENTIFYING INFORMATION

Child's Name _____ (M)____ (F)___Date of Birth_____

Street Address _____

City _____ State _____ Zip Code _____

Telephone/TTY _____ Email address _____

I'd like to receive CHC's free e-newsletter with CHC news and information: Yes / No

Referred by _____

Parent 1 Full Name _____Age _____

Address _____

Parent 2 Full Name _____Age _____

Address _____

Parent 1 Job Title _____Telephone #_____

Parent 2 Job Title _____Telephone # _____

Reason for today's evaluation: _____

_____

Other children at home:

Name _____Age _____

_____Age _____

_____Age _____

Which languages are spoken at home?

_____

Child's Doctor _____ Address _____

City _____ State _____ Zip Code _____

Telephone # _____

Mother's previous pregnancies (include miscarriages) _____

Illnesses or complications during pregnancy with this child? _____

List drugs/medications taken during this pregnancy: _____

Where was this child born? _____

Conditions during this child's birth:

Length of pregnancy _____ How long was labor? _____

Was birth by Cesarean Section _____ Breech birth?_____

Birth weight _____ Was baby in intensive care? _____

Did baby need transfusion? _____ Did baby have jaundice? _____

Did baby have anoxia or respiratory distress? _____

Immediately following birth:

Did the baby have difficulty sucking and swallowing in the first few days of life? _____

Were there any feeding difficulties in early infancy? _____

Did the baby have a newborn hearing screening exam? Yes/No (please circle)

- What were the hearing screening results? Pass/Refer (please circle)

Were there any other conditions of concern? _____

_____

Health History

Please note if your child has or has had any of the following:

Allergies	Asthma	Chicken Pox	CMV
Ear Infections	Encephalitis	Frequent colds	Head injuries
Heart problems	High fever	Kidney problems	Measles
Meningitis	Mumps	Scarlet fever	Seizure disorder
Vision problems	Other:		

Are immunizations up to date? _____

(please attach immunization record)

Were there any reactions to immunizations? _____

Has child been hospitalized? _____ Reason for hospitalization _____

Name of hospital _____ Length of stay _____

Has child had surgery? What type and when _____

Has medication ever been used for behavior or emotional issues? _____

Does the child take any medications regularly? _____

DEVELOPMENTAL HISTORY

At what age did child:

Show visual response to mother _____ Crawl _____ Sit _____ Walk _____

Become Toilet Trained _____ Ride a tricycle _____ Bicycle _____

Does child have an unusual gait, fall or lose balance easily? _____

Can child jump _____ hop _____ skip _____Does child prefer right or left hand _____

FAMILY HISTORY

Has any member of your family been treated for: (indicate who)

Deafness or Hearing Loss _____ Developmental delay_____

Language Disorder _____ Learning Disability_____

Reading diffiulty _____ Speech problems _____

Vision problems _____ Other _____

HEARING, SPEECH, LANGUAGE BEHAVIOR

Does child respond to sounds when the source of the sound is out of sight? _____

If so, what specific sounds _____

Does child want TV/Radio excessively loud? _____

Does child distinguish between different sounds? (e.g., telephone vs. doorbell, etc.) _____

Does child respond to his or her name? _____

At what age did:

baby babble? _____ imitate sounds? _____ Say first word? _____

phrases? _____ sentences _____

Does your child understand any words or phrases?
Please list: _____

How do you get your child's attention?
Please describe: _____

How do you communicate with your child? Voice alone _____ Sign _____ Both _____

Give example of communication with child _____

_____

How does your child get what he/she wants? Gesture _____ Voice _____

Voice and Gesture _____ Describe situation: (i.e., "wanting bottle") _____

_____

What speech sounds have you heard your child make? Please list: (i.e., ba,ee,etc.)

_____

Does your child have tendency to "tune in and out" of listening situations? _____

_____

Has child ever been seen by an ear doctor? _____ If yes, please provide information:

Doctor's Name _____ Doctor's Address _____

What did Doctor recommend? _____

Does child wear a hearing aid? _____When was it purchased?_____

Who recommended the hearing aid? _____

Name and Model _____ Ear: Right _____ Left _____ Both _____

When does the child wear the hearing aid? _____

Does child use an FM system? _____

Has child been seen by any other doctors (e.g. eye doctor, neurologist, kidney specialist)?
If yes, please provide information: _____

_____

SOCIAL AND EMOTIONAL BEHAVIOR

Does child have any specific food preferences? _____

At what age did child play with other children? _____

Does child prefer playing alone or with other children? _____

What ages are child's playmates? _____

Is your child more interested in people? _____ or objects? _____

Is your child easily distracted? _____

Is your child easily managed at home? _____

at school? _____

SCHOOL INFORMATION

What school does your child attend? _____ Grade _____

Address _____

Phone number: _____Classroom Teacher _____

List schools previously attended:

_____

Name of School Address Dates of Attendance

_____

Name of School Address Dates of Attendance

Has your child repeated a grade? _____Which one? _____

If child has received special services at school (resource room, remedial reading, speech therapy, supplement help, special class or school, psychological evaluation, etc.) please answer the following section.

Type of Service Date Received Name of Specialist

_____

_____

_____

HOME INFORMATION

Has this child's development been in any way different from that of the other children in your family? (If your answer is yes, please describe) _____

_____

_____

Is there agreement in your household on the nature of your child's problem?

_____

_____

_____

FINANCIAL INFORMATION

Family Income _____

Do you or your child receive:

SSI _____#_____

Welfare _____#_____

Medicaid _____#_____

Medicare _____#_____

Do you have Health Insurance and/or Major Medical? _____

If yes - Name of Carrier _____Policy # _____

Form Completed by _____

Relationship to child _____

G: YRamos\Ann\Forms\child.frm

FISHER'S AUDITORY PROBLEMS CHECKLIST – PARENT'S COPY

Child's Name_____ Date_____

Please place a check mark before each item that is considered to be a concern by the observer:

____ 1. Has a history of hearing loss.
____ 2. Has a history of ear infections(s).
____ 3. Does not pay attention (listen) to instruction 50% or more of the time.
____ 4. Does not listen carefully to directions – often necessary to repeat instructions.
____ 5. Says "Huh?" and "What?" five times or more per day.
____ 6. Cannot attend to auditory stimuli for more than a few seconds.
____ 7. Has a short attention span.
(if this item is checked, Also check the most appropriate time frame.) _____ 0-2 minutes _____ 5-15 minutes _____ 2-5 minutes _____ 15-30 minutes
____ 8. Daydreams – attention drifts – not with it at times.
____ 9. Is easily distracted by background sound(s).
____ 10. Has difficulty with phonics.
____ 11. Experiences problems with sound discrimination.
____ 12. Forgets what is said in a few minutes.
____ 13. Does not remember simple routine things from day to day.
____ 14. Displays problems recalling what was heard last week, month, year.
____ 15. Has difficulty recalling a sequence that has been heard.
____ 16. Experiences difficulty following auditory directions.
____ 17. Frequently misunderstand what is said.
____ 18. Does not comprehend many words - verbal concepts for age/grade level.
____ 19. Learns poorly through the auditory channel.
____ 20. Has a language problem (morphology, syntax, vocabulary, phonology).
____ 21. Has an articulation (phonology) problem.
____ 22. Cannot always relate what is heard to what is seen.
____ 23. Lacks motivation to learn.
____ 24. Displays slow or delayed response to verbal stimuli.
____ 25. Demonstrates below average performance in one or more academic area(s).

Scoring: Four percent credit for each numbered item not checked.

Number of items checked _____ x 4 = _____.

Normative data – grade score from reverse side _____.