SUNY New Paltz
Speech, Language and Hearing Center
1 Hawk Drive, HUM 9B
New Paltz, New York 12561
Telephone: (845) 257-3600

CHILD AUDIOLOGICAL INFORMATION FORM

Please answer the questions as fully and accurately as possible, and bring this form with you to the evaluation appointment. All of the information we collect is confidential and is used only by the Speech Language and Hearing Center (SLHC) staff.

Today's date: _____

GENERAL INFORMATION:

Child's name: _____

Birthdate: _____ Age: _____ Sex: _____

Guardian's name: _____

Email address: _____

Address: _____

_____

Telephone: _____

Language(s) spoken at home: _____

Child's physician: _____ Physician's phone: _____

Physician's address: _____

_____

PRENATAL & BIRTH HISTORY:

Length of pregnancy for this child: _____

Complications of labor/birth? Yes ☐ No ☐ If yes, please describe: _____

_____

Birth weight: _____ Hospital: _____ Length of nursery stay: _____

Any medical history of:

Oxygen deprivation: Yes ☐ No ☐ Respiratory distress: Yes ☐ No ☐

Jaundice: Yes ☐ No ☐ RH factor: Yes ☐ No ☐ Transfusions: Yes ☐ No ☐

Family history of congenital hearing loss: Yes ☐ No ☐ Congenital deformities: Yes ☐ No ☐

Other complications: _____

DEVELOPMENTAL HISTORY:

At how many months of age did the child:

Sit alone without support _____ First crawl _____ Walk unaided _____ Toilet train _____

If the child is **under 6 months of age**:

Does he/she startle to sound? Yes ☐ No ☐

Wake to loud noise like the vacuum? Yes ☐ No ☐

Calm to your voice? Yes ☐ No ☐

If the child is **5 to 7 months of age**:

Does he/she recognize his/her name? Yes ☐ No ☐

Turn to sound? Yes ☐ No ☐

React to music? Yes ☐ No ☐

At what age did the child: Babble _____ Imitate sounds _____ Say first word _____ Use sentences _____

Has the child had any developmental/educational/neurological evaluations? Yes ☐ No ☐

If yes, explain: _____

_____

Are there any speech and/or language difficulties? Yes ☐ No ☐

If yes, please describe: _____

_____

How is the child doing in school? _____

Type of class placement: _____

MEDICAL HISTORY:

Illnesses requiring hospitalization: _____

_____ When: _____

Long term medications: _____

Condition: _____

Is there a history of:

Ear infections? Yes____ No____ Frequent? Yes____ No____ Date of most recent infection: _____

Treated by: _____

Meningitis? Yes _____ No _____ If yes, when?_____ Treated by: _____

Maternal rubella? Yes _____ No _____ If yes, at what stage of pregnancy: _____

Measles? Yes _____ No _____ If yes, when?_____ Treated by: _____

Mumps? Yes _____ No _____ If yes, when?_____ Treated by: _____

Fevers over 104? Yes _____ No _____ If yes, when?_____ Treated by: _____

Seizures? Yes _____ No _____ If yes, when?_____ Treated by: _____

Family genetic anomalies? Yes _____ No _____ If yes, describe: _____

Ear surgery? Yes _____ No _____ If yes, when?_____ Performed by: _____

Other surgery? Yes _____ No _____ If yes, please specify when, what type, and performed by: _____

_____

Other conditions/diagnosis: _____

_____

OTHER AUDIOLOGICAL HISTORY:

How does the child communicate his/her needs? _____

_____

Does the child appear to hear? Yes _____ No _____

Does the child want TV excessively loud? Yes_____No_____

Does the child understand verbal requests, commands, directions, etc.? Yes _____ No _____

Does the child repeat what is said to her/him? Yes _____ No _____

Does the hearing seem to fluctuate? Yes _____ No _____

Does the child seem to have unusual difficulty hearing in a noisy environment? Yes ☐ No ☐

Does the child get distracted easily in a noisy environment? Yes ☐ No ☐

Is there a family history of hearing loss? Yes ☐ No ☐ If yes, please describe who: _____

_____

Has the child's hearing ever been screened or tested before? Yes ☐ No ☐

If yes, where: _____ When: _____

Results: _____

_____

Has an assistive device or hearing aid ever been recommended? Yes ☐ No ☐

If yes, what was the specific recommendation: _____

_____

Has the child ever had a speech and/or language evaluation? Yes ☐ No ☐

If yes, Where: _____ When: _____

Results: _____

_____

Where would you like the evaluation results sent?

_____

_____

_____

Authorizing Signature: _____

Authorizing Name (print):_____Date: _____