Heard It Through The Grapevine Audiology, PC

ADULT AUDITORY PROCESSING CASE HISTORY

PATIENT INFORMATION

First Name: _____ Last name: _____ Age: _____

Date of Birth: _____ Date: _____

What is the primary reason you are concerned about your auditory processing skills?

_____

FAMILY HISTORY

Is there a family history of any of the following medical conditions?

- ☐ Auditory Processing Difficulties
- ☐ Autism Spectrum Disorder
- ☐ ADHD/ADD
- ☐ Other Learning Differences
- ☐ Dyslexia
- ☐ Children with Auditory Processing Difficulties and or any of the above

HAVE YOU EVER BEEN HOSPITALIZED FOR / DIAGNOSED WITH / TREATED FOR:

- ☐ Hyperbilirubinemia
- ☐ Low birth rate
- ☐ Prematurity
- ☐ Autism
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Measles
- ☐ Influenza
- ☐ Cancer
- ☐ Learning Disability
- ☐ Prenatal Drug Exposure
- ☐ Developmental Delays
- ☐ Anoxia (Lack of Oxygen)
- ☐ Fine Motor and/or Gross Motor Delays
- ☐ Cytomegalovirus (CMV)
- ☐ Other diagnoses _____
- ☐ Chickenpox
- ☐ Septicemia
- ☐ Diabetes
- ☐ Sickle Cell
- ☐ Rubella
- ☐ ADHD/ADD
- ☐ Depression
- ☐ Dyslexia
- ☐ Balance/Gait issues
- ☐ Asperger's
- ☐ Depression
- ☐ Speech and/or Language Disorder
- ☐ TBI
- ☐ Concussions
- ☐ COVID-19
- ☐ Seizure Activity
- ☐ Epilepsy
- ☐ Stroke
- ☐ Vision Issues
- ☐ Anxiety
- ☐ Hypotonia
- ☐ Visual Processing Issues
- ☐ Auditory Processing Disorder
- ☐ Exposure to neurotoxins

Please list the month and year you either received a COVID-19 vaccine or were diagnosed with COVID-19.

_____

Please list any other hospitalizations and/or surgeries _____

_____

Do you currently play or have you played contact sports in the past? _____

_____

EDUCATIONAL HISTORY

Level of Education: ☐ High School ☐ Some College ☐ Associates ☐ Bachelor ☐ Advanced Degree

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Have you ever had concerns regarding academic performance? _____

Are any other tests being conducted through other professionals? _____

Are you right or left-handed? _____

Are you bilingual? _____

Have you received musical training? ☐ Yes ☐ No If yes, how many years? _____

Did you ever have a history of concerns in any of the following areas?

☐ Reading ☐ Writing ☐ Math ☐ Learning letter identification and/or letter sounds

Did you ever receive a 504 Plan at school for any disabilities: ☐ Yes ☐ No

Did you ever receive Special Education Services at school under any of the following categories:

☐ Auditory Impairment (AI) ☐ Autism (AU) ☐ Deaf-Blindness (DB)

☐ Emotional Disturbance (ED) ☐ Intellectual Disability (ID) ☐ Multiple Disabilities (MD)

☐ Orthopedic Impairment (OI) ☐ Other Health Impairment (OHI) ☐ Learning Disability (LD)

☐ Speech Impairment (SI) ☐ Traumatic Brain Injury (TBI) ☐ Visual Impairment (VI)

☐ Non-Categorical Early Childhood (NCEC)

HISTORY OF EAR PROBLEMS

Ear infections: ☐ NONE ☐ LEFT ☐ RIGHT ☐ BOTH If yes, specify what ages, how many and how often:

_____

When was last ear infection: _____

Ever had "tubes" in ears? ☐ NONE ☐ LEFT ☐ RIGHT ☐ BOTH If yes, specify when & how many times:

_____

Has your hearing been tested before? ☐ YES ☐ NO If yes, specify when & where: _____

_____

Do you have an ENT physician? _____

MEDICATIONS

Do you take any prescription medications on a regular basis? Please list.

Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____

DOCTORS (SPECIALISTS)

Please list other doctors and/or specialists from which you are receiving treatment:

_____

_____

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HISTORY OF THERAPEUTIC SERVICES

Please list any past history of therapeutic services received and the age / number of years received.

Physical Therapy: _____

Occupational Therapy: _____

Speech Therapy: _____

Vision Therapy: _____

Auditory Training: _____

Psychology: _____

Other: _____