Lyric Audiology, PLLC
Bringing Words and Music to Your Ears

Harriet B. Jacobster, Au.D.
ASHA Certified in Audiology
Licensed Hearing Aid Dispenser

PEDIATRIC CASE HISTORY

Date ________________

Child's Name (Please Print)____

Address: ____

Phone: __________________________________

Birthdate ______/_______/_______ Age: __________ Gender: ☐ Female ☐ Male

Child lives with: ___ both parents ___ Mother ___ Father ___ other(explain)_______________

Names and ages of any other children at home: __________________________________

____

I. Hearing History

Do you have any concerns about your child's hearing? ☐Yes ☐No

If yes, briefly explain: ____

____

Does anyone in your family have hearing loss (immediate and extended family) that began before the age of 30? ☐Yes ☐No
Does your child consistently respond to your voice? ☐Yes ☐No
Does your child respond to loud noises? ☐Yes ☐No
When sound is present or someone is speaking, does your child search to find where the sound is coming from? ☐Yes ☐No
Does your child respond to sounds from other rooms? ☐Yes ☐No
Does your child enjoy listening to music? ☐Yes ☐No
Has your child's hearing ever been tested? ☐Yes ☐No
If yes, please list results:-_____________________________________
Does your child wear hearing aid(s)? ☐Yes ☐No
If yes, when was your child first fit?______________________________
Does your child use an auditory trainer? ☐Yes ☐No
Does your child receive preferential classroom seating? ☐Yes ☐No

II. Pregnancy And Birth History

Was the pregnancy abnormal in any way? ☐Yes ☐No
Was the delivery abnormal in any way? ☐Yes ☐No

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Was the delivery premature? ☐Yes ☐No
Did the mother have any illness during the pregnancy? ☐Yes ☐No
Did the mother take any medication during the pregnancy? ☐Yes ☐No
After birth, did your child have:
- Breathing difficulties? ☐Yes ☐No
- Require an incubator? ☐Yes ☐No
- Any head, neck or ear abnormalities? ☐Yes ☐No
- Feeding problems? ☐Yes ☐No
- Surgery? ☐Yes ☐No
- Any infections requiring medication? ☐Yes ☐No
- Treatment for jaundice (yellow coloration of the skin)? ☐Yes ☐No

If yes to any of the above, briefly explain: ____

____

III. Medical History

1. Do you have any medical concerns about your child? ☐Yes ☐No
   If yes, briefly explain: ____

____

2. Please check if your child has had any of the following:
   Ear infections _____ Meningitis _____ Seizures _____ Ear surgery _____
   Measles _____ Kidney problems _____ Hospitalization _____ Mumps _____
   Vision problems _____ Head trauma/injury _____ Chicken pox _____
   Allergies _____ Noise exposure (e.g. loud music) _____ Asthma _____

Briefly explain any you checked: ____

____

Other significant medical concerns: ____

____

Please list any prescription or over-the-counter medications your child is taking and for what

reason(s): ____

____

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IV. Physical Development History

Do you have any concerns about your child's physical development? ☐Yes ☐No
If yes, briefly explain: ____

____

About what age did your child: hold his/her head erect ______________________________
sit unsupported____________________ walk alone _________________________________
At what age was toilet training completed? ____

Does he/she lose their balance or fall easily? ☐Yes ☐No
Does he/she seem uncoordinated or clumsy? ☐Yes ☐No
Is your child ☐Right ☐Left ☐ Mixed handed?

V. Educational history

SCHOOL: ___________________________________Grade: ______________________

Address: ____

1. School Performance is:
   ☐ Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Poor

2. Has your child ever repeated a grade? ☐ Yes ☐ No.
   If yes, which grade and why: ____

3. Does your child now, or has in the past, receive special assistance in school (i.e. remedial reading, resource room, speech therapy, etc.)? ☐ Yes ☐ No. If yes, please explain:

   ____

   ____

4. Is your child better at some subjects than others? ☐ Yes ☐ No

   Stronger: ____

   Weaker: ____

5. Does your child have difficulty with:

Phonics	☐ Yes	☐ No
Spelling	☐ Yes	☐ No
Reading Mechanics	☐ Yes	☐ No
Reading Comprehension	☐ Yes	☐ No

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6. Do you think your child has a language problem (i.e. understanding language, using appropriate language, etc.)? ☐ Yes ☐ No
If Yes, explain: ____

____

7..How would you rate your child's vocabulary? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

8. Does your child have a diagnosis of any of the following?

Learning Disability	☐ Yes	☐ No
Mental Delays	☐ Yes	☐ No
Speech/language disorder	☐ Yes	☐ No
Attention Disorders	☐ Yes	☐ No

V. Speech and Language History

1. Do you have any concerns about your child's speech and language? ☐Yes ☐No
If yes, briefly explain: ____

____

2. About what age did your child: follow simple directions ______________________
say his/her first word _______________ put two words together _______________
3. Did your child continue adding words after the first word? ☐Yes ☐No
4. If your child is 2 years old or younger, how many words does he/she use? _______________

5. Does your child often use gestures when communicating? ☐Yes ☐No
Is your child's speech understood by:
parents ☐Yes ☐No siblings ☐Yes ☐No other adults ☐Yes ☐No

VI. Behaviors and Characteristics

1. What behaviors or symptoms make you suspect that your child may have an Auditory Processing problem?

____

____

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2.Does your child exhibit any of the following behaviors or characteristics?

- ☐ Difficulty hearing
- ☐ Says “huh” or “what” frequently?
- ☐ Extremely sensitive to loud sounds
- ☐ Appears confused in noisy places
- ☐ Easily upset by new situations
- ☐ Difficulties following directions or instructions
- ☐ Does opposite of what is requested
- ☐ Restless
- ☐ Overly active
- ☐ Short attention span
- ☐ Impulsive
- ☐ Easily distracted
- ☐ Poor listener
- ☐ Difficulties recalling short or long term information
- ☐ Difficulties with time concepts
- ☐ Does not complete assignments
- ☐ Tires easily
- ☐ Dislikes School
- ☐ Awkward or clumsy
- ☐ Uncoordinated or disorganized
- ☐ Daydreams
- ☐ Forgetful
- ☐ Often asks for repetition
- ☐ Reverses words, numbers or letters
- ☐ Prefers solitary activities
- ☐ Disruptive or rowdy
- ☐ Shy
- ☐ Anxious
- ☐ Lack Self-confidence
- ☐ Give inappropriate responses
- ☐ Lacks motivation
- ☐ Uncooperative, disobedient
- ☐ Obsessive, repeats actions
- ☐ Destructive
- ☐ Inappropriate social behavior
- ☐ Easily Frustrated
- ☐ Irritable
- ☐ Fakes/exaggerates illness
- ☐ Depressed
- ☐ Difficulties reading/writing

If yes to any of the above, briefly explain: ____

____

____

____

Any other comments you feel would be helpful in your child’s evaluation:

____

____

____

______________________________ ____________________
Signature of person completing form Date

____
Relationship to child

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