

AUDIOLOGY SERVICES
CASE HISTORY FORM- CONFIDENTIAL

Child's Full Name: _____ School: _____ Grade: _____
Birthdate: _____ Age: _____ Teacher's Name: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell phone: _____ M/F Work phone: _____
Father's Name: _____ Age: _____ Employer: _____
Mother's Name: _____ Age: _____ Employer: _____
Parent's are: Married _____ Divorced _____ Separated _____ Live Together _____ Other _____
Who has legal custody of child? Both Parents: _____ Father: _____ Mother: _____ Other: _____
Is your child adopted? Yes: _____ No: _____. If yes, which country? _____
If yes, what approximate date: _____ At What Age: _____
Who Referred You to Audiology Services? _____
Has your child been seen here before? Yes: _____ No: _____ Approximately When? _____
Does your child have Health Insurance? Yes: _____ No: _____
If yes, What Insurance Company? _____
HMO _____
PEDIATRICIAN'S NAME: _____ Phone: _____
May we release information to your pediatrician? Yes _____ No _____

BIRTH HISTORY; CHECK ALL THAT APPLY:

Name of Birthing Hospital: _____

Newborn Hearing Screening Results: Passed: _____ Failed: _____ Did not Test: _____ Do Not Know: _____

Gestational Age at Birth: _____ Birth Weight: _____
In NICU _____ If yes, how long? _____ Why? _____
Ventilator? _____ If yes, how long? _____

My Child is Diagnosed With the Following:

CMV _____	Metabolic Disorder: _____	Cardiac abnormality: _____
Jaundice at birth: _____	Diabetes: _____	Cancer: _____
Seizures: _____	CP: _____	Cleft Lip/Palate: _____
Down Syndrome: _____	Spina Bifida: _____	Other: _____
Chromosome Abnormality: _____	Kidney Disorder: _____	
Hydrocephalus: _____	Vision Impairment: _____	
Hearing Impairment: _____	Absent Corpus Collosum: _____	

Private Audiologist name: _____
Hearing Aid Model: _____

Additional Medical History:

Head Injury _____ Explain: _____
Frequent Ear Infections: _____ How many?: _____ Seen an ENT? _____
Allergies: _____ please list: _____
Tonsillectomy: _____ Adenoidectomy: _____
Snores at night: _____
Meningitis: Bacterial: _____ Viral: _____ What Age: _____
Asthma: _____

DELAYED DEVELOPMENTAL MILESTONES IN THE FOLLOWING AREAS:

Walking: _____	Ability to Follow verbal directions: _____	Number of Words : _____
Use of Speech: _____	Speech Articulation: _____	Speaks _____ Understands _____
Social Skills: _____	Sensory Integration Difficulties: _____	
Fine Motor Skills: _____	Gross Motor Skills: _____	

AUTISM: _____ **ASPERGER:** _____ **PDD:** _____ **SUSPECTED AUTISM OR PDD:** _____

Current Medications: _____

How many children are in the family?: _____

Family History of Childhood or Young Adult Hearing Loss? _____

What Relationship to Your Child? _____

Check the Following That is True For Your Child:

Plays an instrument: _____ Which Instrument(s): _____

Regular Exposure to Power Tools: _____ lawnmower _____ leaf blower _____

Chainsaw: _____ Firearms: _____ racecars / motorcycles: _____

IPOD: _____ MP3 _____

Do You Consider Your Child's Progress in School to be : Average: _____ Above: _____ Below: _____

Currently, is Your Child in the RTI Process? _____ If yes, case Manager's Name: _____

Does Your Child Currently Receive Services From Any of the Following Special Education Programs From the School System?: Check all the apply:

Emotional/Behavioral Disorder: _____

Speech Impaired: _____

Gifted Program: _____

SLP name: _____

Deaf/Hard of Hearing: _____

Visually Impaired

Learning Disability: _____

Other Health Impaired: _____

Mildly Intellectually Impaired: _____

Specify: _____

Moderately Intellectually Impaired: _____

Orthopedically Impaired: _____

Severely Intellectually Impaired: _____

To whom in the school system should we send a copy of today's test results? _____

I grant my permission for hearing testing of my child at Cobb County Public School Audiology Services. I also grant permission for Audiology Services to obtain all medical records or school records of my child from any medical facility....In addition, I recognize that the cost of any services or tests performed by physicians or *outside medical services* are the sole financial responsibility of the patient and the patient's family. **The Cobb County School System shall not be responsible for the payment of nay such services or tests whether or not any such tests** or services have been recommended by the Cobb County School System Audiologists or by any other personnel employed by the Cobb County School System.

I understand that this consent and authorization may be revoked in writing by the patient's legal guardian at anytime.

Signature: _____ Date: _____

I grant permission for the test results and background information to be released to My Child's School as well as the following:

1) _____

2) _____

3) _____

I understand that this consent and authorization may be revoked in writing by the patient's legal guardian at anytime.

Signature: _____ Date: _____