ADEPT AUDIOLOGY
We take hearing to heart

Office - ***941.312.4781*** ◊ *Fax* – ***941.706.1294*** ◊ *Website* - ***www. AdeptAudiology.com***

Intake Information

Date_____ Accompanied By_____ Referred By _____

Name_____ Male _____ Female_____

Phone _____ Date of Birth ____/____/____

Address_____

Email Address_____

Type of Cell Phone iPhone _____ Android_____ Cell Phone Carrier_____

Primary Care Physician: _____Phone:_____

Physician Address:_____

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth_____

Secondary Ins._____ Insurance ID# _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Adept Audiology of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

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PEDIATRIC CASE HISTORY

Patient name (Last,First)_____ **DOB:**__/__/__ **AGE:**___ **DATE:**__/__/__

BACKGROUND INFORMATION

Mother:_____ DOB:__/__/__ Address:_____

Phone:(___)_____ Occupation:_____ Place of employment:_____

Father:_____ DOB:__/__/__ Address:_____

Phone:(___)_____ Occupation:_____ Place of employment:_____

Email:_____ Child lives with:_____

Person to contact in case of emergency:_____Relationship:_____Phone:(___)_____

Person completing questionnaire:_____ Relationship to client:_____

BIRTH AND PRENATAL HISTORY

Birth weight:_____ Premature? ☐Yes ☐No How early?_____

Were there any complications during pregnancy or at delivery?_____

Was birth by caesarian or breech? _____

At birth did the baby have the following: (please circle)

Anoxia (blue color) Yes No Respiratory distress (breathing problems) Yes No

Jaundice (yellow color) Yes No NICU Yes No If "yes", how long?_____

Swallowing problems Yes No Down syndrome/Trisomy 21 Yes No

Cleft lip/palate Yes No Other:_____

Did child pass the newborn hearing screening? Yes No If "no", explain_____

FAMILY HEARING HISTORY

Please list family members of the child who have a hearing loss:

Relationship to child	Age	Age problem began	Severity of hearing loss	Hearing aids (Yes or No)

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MEDICAL INFORMATION

Name of child's physician:_____Date of last visit:__/__/__

(Newborn patients STOP here)

Circle if the child has ever had the following:

Ear infection	Tubes in the eardrum	Migraines	Asthma
Ear Pain	Ringing in ears	Excessive ear wax	Seizures
Head injury	Allergies	Meningitis	Dizziness
High Fever			

Major medical problems (i.e., heart, lung, physical disabilities) Please explain:_____

_____

Other ear surgeries: Yes No if "yes", list date & reason:

_____

HEARING HISTORY

Check all that apply:

- ☐ Child has trouble hearing
- ☐ Pain in ears
- ☐ Exposure to loud noises
- ☐ Hears noises in ears
- ☐ Falls of loses balance easily
- ☐ Child needs to hear instructions several times
- ☐ It helps the child when people speak loud
- ☐ TV/radio is excessively loud
- ☐ There are sounds that make child uncomfortable
- ☐ The child "tunes in and out" of listening situations
- ☐ My child's teacher/daycare worker has mentioned my child having trouble hearing in school

Are you concerned about your child's hearing? Yes No If "yes", explain

_____

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Patient name:_____

DEVELOPMENTAL HISTORY

Do you have any concerns with your child's development? Yes No If "yes", explain

_____

Has your child been diagnosed with any specific condition? Yes No If" yes", explain

_____

SPEECH HISTORY

When did the child babble normally?

_____

Did he/she, at any time, stop babbling? Yes No

When did he/she begin to talk?

_____

Is his/her speech intelligible to people outside the family? Yes No

Does he/she have any speech problems? Yes No

If yes, please describe:

_____

Are you concerned about your child's speech and language development? Yes No If "yes", explain

_____

SCHOOL/OTHER SERVICES (please circle)

Has your child received speech therapy? Yes No
Where?_____

Describe therapy (how often, how long)

_____

Has your child received physical therapy? Yes No
Where?_____

Describe therapy (how often, how long)_____

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Has your child received occupational therapy? Yes No
Where?_____

Describe therapy (how often, how long)

_____

Has your child received any other services? Yes No
Where?_____

Describe therapy (how often, how long)_____

Has your child received any other services (Educational Evaluation, Vision, Psychology, Psychiatry)? Yes No
Where?_____

What method of education are you using for you child? (Home School. Virtual, Brick and Mortar)

_____

AMPLIFICATION HISTORY (please circle)

Does your child use hearing aids? Yes No

If yes, please answer the following questions.

How long has your child used hearing aids?

_____

In which ear(s) does your child wear hearing aids? Left Right Both

What is the make & model of the left and/or right hearing aid?

_____

If your child used hearing aids in the past is, he/she still wearing aids? Yes No If "no", why?_____

_____

ADDITIONAL NOTES/COMMENTS

_____

_____

_____