APD QUESTIONNAIRE

General Information:

Today's Date:________________________ **Referral Source:**________________________

Patient Name:________________________DOB:__________Parent/Guardian:________________________

Address:________________________________Phone(H):____________________(W)__________

Name of person completing form and relationship to child:________________________

Primary Care Physician (name, address, phone):________________________

Why is your child being referred for APD testing?________________________

When was the problem noticed?________________________

What has been done about this problem (in school, therapy, home)?________________________

List other family members in the home (include name, age and relation ship to child):________________________

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Are there any other languages than English spoken in the home? If yes, which language?________________________

Is there a family history of hearing loss?______________If yes, who?________________________

Is there a family history of learning disorders?______________If yes, who?________________________

Has your child had a comprehensive hearing evaluation?__________If yes, **please provide a copy of the results with this questionnaire.**

Does your child seem sensitive to loud noise?__________ Describe your child's auditory behavior:________________________

____

Is your child able to listen and understand in the presence of background noise?________________________

Does your child have a history of ear infections, middle ear fluid, or drainage from the ears?________________________
If yes, How often?____________________When was the last episode?________________________

Has your child ever had tubes placed in the eardrums?____________If yes, when and how many times?________________________

Does your child have any visual problems?____________Has your child previously been tested for APD?________________________
If yes, who evaluated and what were the results.________________________

Has your child been evaluated for speech and/or language concerns?__________If yes, briefly describe the results of the evaluation.________________________

Is your child's speech intelligible to unfamiliar listeners?__________Does your child receive speech/language therapy?________

Has your child been evaluated for ADD/ADHD?__________If yes, what were the results?________________________
Does your child take medication for ADD/ADHD?________________________

Were there any complications with pregnancy or delivery?________________________
Mark any that apply:________Jaundice ________premature ________required oxygen ________low birth weight

________In NICU ________hyperbilirubinemia ________exposed to drugs and/or alcohol inutero

Is your child generally healthy?________List any medical conditions that your child has been diagnosed with.________________________

____

What medications does your child take?________________________

Has your child been diagnosed with any of the following? Please specify approximate frequency and dates.

Frequent colds________________ Respiratory infections________________ Sinusitis________________

Ear infections________ High fevers________ Allergies________
Developmental delay________ Failure to thrive________ Dyslexia________

Autism________ Cleft palate________ Seizures________

Head injury________ Coma________ Other________

Has your child had any of the following tests completed? If yes, what were the results?
EEG________ MRI________ CT scan________
ABR________ MRA________ Other________

Developmental History:

At what age did your child:
Say his/her first word?________ Start using two-word sentences?________
Roll over?________Crawl?________Walk?________

Did your child's development stop at any point?________

Personality Traits/Physical Characteristics:

Circle any trails that apply to your child:

Hyperactive	Self-sufficient	Tired	Circle under eyes	Easy to anger	Dependent	Independent
Aggressive	Under active	Calm	Distractible	Impulsive	Doesn't try	Has few friends
Difficulty sleeping	Too controlled	Sulks	Frequent nausea	Easily frustrated	Lacks confidence	Short attention span
Disorganized	Temper tantrums	Irritable	Competitive	Poor handwriting	Cries easily	Poor social skills
Poor musical skills	Responsible	Fearful	Jokes a lot	Helps others	Fast worker	Depressed
Organized	Immature	Follows directions poorly				

Educational Information:

What School does your child attend?________ Grade:________

Has your child ever repeated a grade?________ How does your child feel about school?________

Does your child's academic performance fall below verbal/ intellectual ability?________

Can your child follow directions?________ Which subject(s) does your child excel?________

How does your child perform in reading?________Spelling?________

Does your child have a tendency to reverse numbers or letters when reading, speaking or writing?________

Does your child learn best by: ________Seeing? ________Hearing? ________Doing?

Has your child been identified with a Learning Disability?________

Classroom Environment:

Does your child receive preferential seating?________ How many students are in your child's classroom?________

Does the classroom have a soundfield system?________Is the classroom carpeted?________

Is there a lot of extraneous noise in the classroom (street noise, fans, air conditioners)?________

Please add any additional information that you would like or feel is relevant.________

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Patient Name:________ Date:________

FISHER'S AUDITORY PROBLEMS CHECKLIST

Student Name ____ District/Building __________________________

Date ____________________ Grade__________ Observer _____________________ Position _________________

Please place a check mark before each item that is considered to be a concern by the observer:

___ 1. Has a history of hearing loss.
___ 2. Has a history of ear infection(s).
___ 3. Does not pay attention (listen) to instruction 50% or more of the time.
___ 4. Does not listen carefully to directions - often necessary to repeat instructions.
___ 5. Says "Huh?" and "What?" at least five or more times per day.
___ 6. Cannot attend to auditory stimuli for more than a few seconds.
___ 7. Has a short attention span.
(if this item is checked, also check the most appropriate time frame.)
__________ 0-2 minutes __________ 5-15 minutes
__________ 2-5 minutes __________ 15-30 minutes
___ 8. Daydreams - attention drifts - not with it at times.
___ 9. Is easily distracted by background sound(s).
___ 10. Has difficulty with phonics.
___ 11. Experiences problems with sound discrimination.
___ 12. Forgets what is said in a few minutes.
___ 13. Does not remember simple routine things from day to day.
___ 14. Displays problems recalling what was heard last week, month, year.
___ 15. Has difficulty recalling a sequence that has been heard.
___ 16. Experiences difficulty following auditory directions.
___ 17. Frequently misunderstands what is said.
___ 18. Does not comprehend many words - verbal concepts for age/grade level.
___ 19. Learns poorly through the auditory channel.
___ 20. Has a language problem (morphology, syntax, vocabulary, phonology).
___ 21. Has an articulation (phonology) problem.
___ 22. Cannot always relate what is heard to what is seen.
___ 23. Lacks motivation to learn.
___ 24. Displays slow or delayed response to verbal stimuli.
___ 25. Demonstrates below average performance in one or more academic area(s).

Scoring: Four percent credit for each numbered item not checked.

Number of items not checked __________ x 4 = __________.

Normative data - grade score from reverse side __________.

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