Audiology Associates of Redding

Pediatric Audiologic Intake Form

Date: _____

Child's name: _____ Date of birth: _____
Age: _____ Gender: M / F Parent/guardian's Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Other phone: _____
Parent/guardian's email address: _____
Referred by: _____ Primary care physician: _____
Name of person completing this form: _____ Relation: _____
Driver's License: _____ SSN: _____ Employer: _____
Reason for today's visit: _____

GENERAL

Have you ever questioned your child's ability to hear normally? ☐ Yes ☐ No
Has your child's hearing been tested before? ☐ Yes ☐ No
If yes: When/Where? _____ What were the results? _____
Do any of the child's relatives have hearing problems? ☐ Yes ☐ No
If yes: Who? _____ Age of identification? _____

PRENATAL HISTORY

Please check any of the conditions that occurred during pregnancy:

☐ HIV	☐ Maternal illness/infection	☐ Lack of oxygen
☐ Alcohol abuse	☐ Toxoplasmosis	☐ Rubella
☐ Substance abuse	☐ Gestational diabetes	☐ Syphilis
☐ Cytomegalovirus (CMV)	☐ Preeclampsia	☐ Herpes

Were there any additional pregnancy complications? _____

BIRTH HISTORY

Length of pregnancy: _____ Child's weight at birth: _____
Please check if any were applicable during delivery/after birth:

☐ Emergency caesarean	☐ Oxygen administered	☐ Phototherapy lights
☐ Mechanical ventilation	☐ Jaundice	☐ Aminoglycoside antibiotics
☐ Congenital anomalies	☐ NICU stay	☐ Meconium aspiration
☐ Meningitis	☐ Feeding tube	
☐ Other complications	☐ Syndrome	

Please describe: _____

CHILD'S HEARING HISTORY

Has your child had a history of ear infections/ear drainage? ☐ Yes ☐ No

Has your child had medical/surgical treatment for his/her ears? ☐ Yes ☐ No

If yes, when? _____ What procedure and where? _____

Does he/she ever complain of pain or fullness in the ears? ☐ Yes ☐ No

Has your child ever described noise in the ears? ☐ Yes ☐ No

Does your child fall or lose balance easily? ☐ Yes ☐ No

HEALTH HISTORY

Has your child experienced any of the following? If yes, please list date of occurrence:

☐ Measles	_____	☐ Tonsillitis	_____	☐ Chickenpox	_____
☐ Allergies	_____	☐ Mumps	_____	☐ Frequent colds	_____
☐ Scarlet Fever	_____	☐ Flu	_____	☐ Meningitis	_____
☐ Sinusitis	_____	☐ Encephalitis	_____	☐ High fevers	_____
☐ Seizures	_____	☐ Head injury	_____	☐ Blood transfusion	_____

Any other serious illness or surgery? ☐ Yes ☐ No

Does your child have any developmental delays? ☐ Yes ☐ No

Please list any medications as well as dosage and frequency (including non-prescriptions) your child is currently taking or has taken recently: _____

SPEECH-LANGUAGE DEVELOPMENT

How do you feel your child's speech, language and basic communication skills are developing? _____

Age of your child's first word : _____

How many words would you estimate your child uses? _____

Is your child currently receiving speech therapy services? ☐ Yes ☐ No Comments _____

Are there multiple languages spoken in the home? ☐ Yes ☐ No What languages? _____

Please review and check the following boxes:

☐ I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, health care providers, assignees and/or beneficiaries and all other related persons.

☐ I allow for voice messages from this practice to be left on any provided phone number.

☐ I acknowledge that I have had the opportunity to review a copy of Audiology Associate's privacy notice. (Available in our office and on our website.)

☐ I allow the following individuals (e.g. spouse/family members/caregivers) to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless Audiology Associates is notified otherwise.

_____

☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to Audiology Associates of Redding. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by Audiology Associates of Redding.

_____ _____

Signature of Patient, Parentor or Legal Guardian Date