clarity
Discovering Potential
Empowering Communication
Transforming Lives

Initial Questionnaire: Medical, Family and Developmental History

The purpose of this *questionnaire is to gather information about your child and family before your child's evaluation. Your answers* will allow us to plan the evaluation specifically for your child. Do not worry if you do not have information to answer every question, as we will be discussing this further at your child's appointment. We appreciate your time and effort in completing this questionnaire. If you need additional space, please write on the back of the page.

GENERAL INFORMATION

Date: _____ Form Completed By: _____

Relationship to Child: _____

Child's Name: _____
(First) (Middle) (Last) ("Nick Name")

Sex: _____ Birth Date: _____ School Grade (If In School): _____

Circle One: Adopted Biological Foster

At what age did the child come into the home (if not biological)? _____

Parent Name: _____ Phone #: _____

Address: _____

Guardian Name (if different than parent): _____

Phone #: _____ Address: _____

Who recommended or referred your child for this appointment? _____

_____

Who is your child's primary care physician? _____

What are the concerns you have about your child? _____

_____

_____

When was this first noticed? _____

PREGNANCY, BIRTH AND HEALTH HISTORY

Number of pregnancies of child's biological mother: _____

Has the mother had miscarriages, abortions, or stillbirths? (Please list):_____

_____

During the pregnancy with the child, did the mother:

	Yes	No	Further Description of Problem
Experience infection or other illness	___	___	_____
Have toxemia	___	___	_____
Have bleeding	___	___	_____

Have unusual physical strain or injury ___ ___ _____

Have unusual emotional strain ___ ___ _____

Drink alcoholic beverages ___ ___ _____

(indicate how much)

Smoke (indicate how much) ___ ___ _____

Take medication or drugs ___ ___ _____
(other than vitamins/iron)

What other problems did the mother have? _____

Estimated length of pregnancy: _____(weeks)

Birth weight: _____ lbs. _____oz. Apgar score, if known: _____ & _____

Type of delivery (check one): Spontaneous_____ Cesarean_____ Forceps_____

Did baby need medical assistance to start to breathe? Yes_____ No_____

Was baby in the Neonatal Intensive Care Unit or other special care nursery? Yes ____ No _____

Check any of the following which baby had in the first month of life:

___Breathing problems ___Convulsions ___Skin Rash ___Excessive Vomiting

___Jaundice(yellow) ___Infection ___Birth Defect

___Excessive crying ___Injury ___Feeding Difficulty

What were your first impressions of your baby? _____

How long did your baby stay in the hospital after birth? _____

Did the baby require any other special treatment at time of birth? Yes_____ No_____

Describe: _____

Did your child pass their newborn hearing screening Yes No Don't know Not screened

Has the child had any of the following?	Yes	No	Ages
1. Convulsions, seizures, fainting spells	___	___	_____
2. Vision or eye problems	___	___	_____
3. Ear infections	___	___	_____
If yes, how many? _____			
4. Hearing problems	___	___	_____
5. Allergies	___	___	_____
If yes, what is child allergic to? _____			
6. Any serious accidents or injuries?	___	___	_____
7. Any poisoning or overdose?	___	___	_____
8. Any problems of weight gain or loss?	___	___	_____

9. Was child ever hospitalized overnight? ___ ___ _____

If yes, when and why? _____

10. Any other chronic or serious health problems? ___ ___ _____

11. Any history of lead poisoning or other toxin exposure? ___ ___ _____

12. Any reaction to an immunization? ___ ___ _____

13. Has child had a medical check-up within the past 12 months? Yes_____ No_____

If any health problems or recommendations, what/by whom? _____

_____

What medications is your child presently taking? _____

14. Has the child ever been given a diagnosis for a developmental or other health-related problem?

If so, please state: _____

_____

FAMILY HISTORY

Mother: Age and General Health: _____

School level completed: _____ Present occupation: _____

Father: Age and General Health: _____

School level completed: _____ Present occupation: _____

Brothers and/or Sisters:

Name:	Age:	Health and Development:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are any siblings deceased? Yes _____ No _____

Are the child's parents related in any way except marriage? Yes _____ No _____

Note below if any of the child's relatives (parents, brothers, sisters cousins, aunts, uncles, grandparents) have had any of the following conditions (*please indicate which relative next to lines checked*):

___ Hyperactivity/attention problems
___ Epilepsy (convulsions, blackouts, seizures)
___ Mental disabilities
___ Cerebral palsy
___ Diabetes or hypoglycemia
___ Hearing loss (not caused by age or noise)
___ Kept back in school
___ Other chronic physical illnesses
___ Speech and/or language problems
___ Drug/alcohol abuse
___ Mental illness or emotional problems
___ Learning disabilities
___ Problems in mathematics
___ Behavioral problems

___ Muscular problems/weakness
___ Genetic disease
___ Physical deformities
___ Heart disease/heart attack (before 40)
___ Vision problems
___ Brain/spinal cord damage
___ Other: _____

Have there been any recent changes or stresses in the family/home? Yes _____ No _____

Explain: _____

_____

DEVELOPMENTAL HISTORY

Please comment on when your child did the following things:

Action	**Time (please circle)**	**Approx. age (please write)**
Roll over (tummy to back)	seemed early / seemed on time / seemed late	
Roll over (back to tummy)	seemed early / seemed on time / seemed late	
Sit up with support	seemed early / seemed on time / seemed late	
Sit up without support	seemed early / seemed on time / seemed late	
Crawl	seemed early / seemed on time / seemed late	
Pull up to stand on furniture	seemed early / seemed on time / seemed late	
Walk alone	seemed early / seemed on time / seemed late	
Give up his/her bottle	seemed early / seemed on time / seemed late	
Drink from sipper top cup	seemed early / seemed on time / seemed late	
Drink from regular cup	seemed early / seemed on time / seemed late	
Finger feed self	seemed early / seemed on time / seemed late	
Feed self with a spoon	seemed early / seemed on time / seemed late	
Dress self	seemed early / seemed on time / seemed late	
Undress self	seemed early / seemed on time / seemed late	
Achieve toilet training for bladder	seemed early / seemed on time / seemed late	Day: _____ Night: _____

Achieve toilet training for bowels	seemed early / seemed on time / seemed late	Day: _____ Night: _____
Smile	seemed early / seemed on time / seemed late	
Coo	seemed early / seemed on time / seemed late	
Babble (da-da-da, ba-ba-ba)	seemed early / seemed on time / seemed late	
Jargon (talk in own special language)	seemed early / seemed on time / seemed late	
Say single words	seemed early / seemed on time / seemed late	
Begin to use phrases (ex. "more juice")	seemed early / seemed on time / seemed late	
Begin to use short sentences	seemed early / seemed on time / seemed late	

SCHOOL HISTORY

Where does your child attend daycare, preschool, or school? _____

Has your child repeated a grade? Yes _____ No _____ Which one?_____

Is your child receiving extra school help? Yes _____ No _____

If yes, please check which kind: Tutoring _____ Counseling _____ Other (list) _____

_____

Has your child had learning problems: In preschool or kindergarten?_____

elementary school? _____ middle school? _____ high school? _____

Has your child ever received Special Education services? Yes_____ No _____

Which grade(s)? _____

Does your child receive physical, occupational or speech therapy in school? Yes _____ No _____

Does your child currently have an Individualized Education Plan (IEP)? Yes _____ No _____

Describe any current school problems: _____

_____

Are there behavior problems in school? Yes _____ No _____

If yes, please list: _____

Does your child have friends at school? Yes _____ No _____

What does your child do after school? _____

Behavior Checklist

If your child is 5 years or younger, please complete "A" - The Child Behavior and Temperament Profile. If your child is 6 or older, please complete "B" - The Pediatric Symptom Checklist.

A. The Child Behavior and Temperament Profile (children under 5). The following list of behaviors and functional problems occur in many children at different times in their lives. Please evaluate your child in reference to these behaviors on a scale of 1 to 5 with a 1 being "no problem" and a 5 being a "severe problem." If it was a problem in the past, please indicate the age.

		No problem				Severe	Age
1.	Eating/stomach problem	1	2	3	4	5	_____
2.	Colicky infant	1	2	3	4	5	_____
3.	Difficult to satisfy	1	2	3	4	5	_____
4.	Trouble with sleeping/nightmares	1	2	3	4	5	_____
5.	Overactivity	1	2	3	4	5	_____
6.	Temper tantrums	1	2	3	4	5	_____
7.	Unusual fears/phobias	1	2	3	4	5	_____
8.	Destructive behavior/hurts self	1	2	3	4	5	_____
9.	Easily frustrated with tasks	1	2	3	4	5	_____
10.	Irritable	1	2	3	4	5	_____
11.	Stubborn	1	2	3	4	5	_____
12.	Poor concentration/short attention	1	2	3	4	5	_____
13.	Not affectionate/poor eye contact	1	2	3	4	5	_____
14.	Difficult to discipline	1	2	3	4	5	_____
15.	Angers easily/strikes out at others	1	2	3	4	5	_____
16.	Acts without thinking	1	2	3	4	5	_____
17.	Cruel to animals	1	2	3	4	5	_____
18.	Tells lies	1	2	3	4	5	_____
19.	Poor self-esteem	1	2	3	4	5	_____
20.	Worries a great deal	1	2	3	4	5	_____
21.	Other behaviors of concern:						

_____

_____

B. The Pediatric Symptom Checklist (children 6 and older). Please mark under the heading that best fits your child:

		Never	Sometimes	Often
1.	Complains of aches and pains	_____	_____	_____
2.	Spends more time alone	_____	_____	_____
3.	Tires easily, little energy	_____	_____	_____
4.	Fidgety, unable to sit still	_____	_____	_____
5.	Has trouble with teacher	_____	_____	_____
6.	Less interested in school	_____	_____	_____
7.	Acts as if driven by a motor	_____	_____	_____
8.	Daydreams too much	_____	_____	_____
9.	Distracted easily	_____	_____	_____
10.	Is afraid of new situations	_____	_____	_____
11.	Feels sad, unhappy	_____	_____	_____
12.	Is irritable, angry	_____	_____	_____
13.	Feels hopeless	_____	_____	_____
14.	Has trouble concentrating	_____	_____	_____
15.	Less interest in friends	_____	_____	_____
16.	Fights with other children	_____	_____	_____
17.	Absent from school	_____	_____	_____
18.	School grades dropping	_____	_____	_____
19.	Is down on him/herself	_____	_____	_____
20.	Visits doctor with finding nothing wrong	_____	_____	_____
21.	Has trouble with sleeping	_____	_____	_____
22.	Worries a lot	_____	_____	_____
23.	Wants to be with you more than before	_____	_____	_____
24.	Feels he/she is bad	_____	_____	_____
25.	Takes unnecessary risks	_____	_____	_____
26.	Gets hurt frequently	_____	_____	_____
27.	Seems to be having less fun	_____	_____	_____
28.	Acts younger than children his/her age	_____	_____	_____
29.	Does not listen to rules	_____	_____	_____
30.	Does not show feelings	_____	_____	_____
31.	Does not understand other people's feelings	_____	_____	_____

32.	Teases others	_____	_____	_____
33.	Blames others for his/her troubles	_____	_____	_____
34.	Takes things that do not belong to him/her	_____	_____	_____
35.	Refuses to share	_____	_____	_____

Please list things your child does well:

_____

_____

_____

What are the most positive features about your child?

_____

_____

_____

How does your child fit in at home with other family members?

_____

_____

_____

What do you feel caused your child's problem?

_____

_____

_____

If you have any additional comments, please write them below.

Thank you very much for spending time filling out this questionnaire.

Patient History

Patient Name _____ Date of Birth _____ Today's Date _____

Referring Physician _____ Physician Phone Number _____

What is your primary reason for this visit: _____

Are you concerned about your child's hearing?_____

Are you concerned about your child's speech?_____

Is there a family history of hearing loss?_____

Is there a family history of speech delay?_____

Has this child had frequent ear infections?_____ Date of last episode _____

Were there any complications at time of birth?_____

Weeks of gestation _____ Birth Weight_____ Apgar Score_____

Were there health complications during the first months of life?_____

Were any of the following present:

NICU or longer than normal hospital stay _____ Jaundice_____ No response to sound _____

Infection at birth _____ In an incubator_____ Use of mechanical ventilator_____

Physical abnormalities_____ High fevers or seizure_____

Did your child pass the newborn hearing screening _____

What ages did your child: Sit alone_____ Walk _____ Say first word _____

Is your child diagnosed with a genetic disorder or developmental delay? Please explain.

_____

_____

Has your child any history of head injuries, major illness, high fevers or hospitalizations?_____

Is your child taking any medication of a regular basis?_____ List medications

_____

WHAT IS A CENTRAL AUDIOTRY PROCESSING EVALUATION?

Central auditory processing (CAP) is, in essence, how the nervous system manages and interprets sound. It is best described as what the brain does with what the ears hear. We all have auditory processing skills, which we use, in varying amounts according to the situation. If these skills are poorer than normal, the listener may have difficulty understanding, remembering or comprehending what is being said by someone else, depending on the circumstances.

To evaluate someone's central auditory processing abilities, a battery of several listening tests is used, and the performance of the test subject is compared to that of individuals with no known central auditory problems. These tests involve having the person being evaluated listen to speech, which is presented in unusual ways or in competition with noise. It is when the auditory system is stressed or taxed in this manner that a central auditory processing disorder shows up. Prior to the CAP portion of the test, a standard hearing test battery including tone thresholds, speech reception thresholds, speech discrimination testing without noise and tympanometry will be done. This must be done as close to the day of the CAP testing as is possible for two reasons. First the volume levels at which the CAP tests are given are based upon individual hearing levels. Variations of five decibels are common from day to day when human hearing is measured. Second, the effect of middle ear fluid on CAP tests is variable, and if conditions suggesting fluid are present at the time of testing, then the results are not quite as valid.

To prepare a child for central auditory processing testing, tell them that they will be wearing headphones (demonstrate this at home if you have a pair), and will be asked to listen and repeat some words. They will also be listening for small sounds (beeps) and will need to push a button when they hear it. It is usually fun to do this. There is no pain, discomfort, wires, electrodes, or needles involved. Depending on the child, testing takes about one hour with another half-hour immediately following to discuss preliminary results with the parents.

*Child's name*_____
*Child's DOB*_____

To Whom It May Concern:

This is a brief description of the three tests included in the battery for assessing central auditory processing disorders. In addition to the audiometric evaluation, the three tests used were: **SSW (Staggered Spondaic Words), Speech-In-Noise, and Phonemic Synthesis Test.** A battery of tests is necessary since a CAP disorder cannot be diagnosed based on only one test. Three tests are usually considered the minimum number of tests necessary to make the diagnosis.

The **SSW Test** is a dichotic listening test. Its complicated scoring allows the examiner to analyze auditory memory skills as well as processing skills.

The **Speech-In-Noise Test** looks specifically at auditory figure-ground problems (problems hearing in background noise) by comparing monaural scores for quiet and +5 signal to noise ratio noise conditions for right and left ears separately.

The **Phonemic Synthesis Test** provides information about the individual's phonemic decoding skills (or ability to process on the speech sound level) as well as additional information about auditory memory skills and sequencing skills.

Norms are available for each of the tests for ages 5 through adult, and each of the above tests are analyzed based on the age-specific norms.

Sincerely,

Holly A. Hurley

Holly A. Hurley, M.S., CCC-A
Audiologist

General Financial Policies

Insurance Disclosure

Please read and sign the following. If you have any questions about this form, please call (864) 331-1400.

I understand that I am responsible for contacting my Insurance Company or Primary Care Physician for authorization of any visits to Clarity before my appointment date. I understand that prior authorization by my insurance company is not a guarantee of payment, and that I am responsible for all costs not covered by my Insurance Company. These costs include, but are not limited to: services provided which are not covered by my policy, balances after insurance payment, or failure to obtain authorization before my appointments. I understand that I may be required to pay all amounts owed at the time services are rendered.

If there are any changes to your or your child's insurance between now and the time of your appointment, please notify us because your new insurance may not cover your service.

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Patient's Name Patient's Date of Birth

I authorize the release of any medical or other information to the insurance company that is necessary to process my insurance claim(s).

_____ _____

Signature of Patient or Parent//Guardian Date

Late Cancellation and no-show policy:

If for any reason, you are unable to keep this appointment, we request you call us 24 hours in advance at 864-331-1400 to cancel or reschedule. If **two** appointments (in any six month time period) are missed or cancelled with less than 24 hours notice, we will reschedule the appointment **after** a six month waiting period from the time of the missed appointment.

I acknowledge that I understand the late cancellation and no-show policy.

_____ _____

Signature of Patient or Parent//Guardian Date

Center for Developmental Services

Directions to the Center for Developmental Services
29 North Academy Street Greenville, SC 29601

Greenville, SC 29601 (864)331-1400 FAX (864)331-1416

*Child's name*_____
*Child's DOB*_____

From Anderson

- Take I-85 to Exit 42 in Greenville (I-185)
- Take I-185 into Greenville (2.4 miles)
- I-185 becomes Mills Ave./29
- Drive 1 mile on Mills Ave. to Augusta St./25
- Turn left onto Augusta St.
- Drive about 1 mile to intersection of Pendleton, River, Main, and Augusta Streets -- veer left onto River St.
- Turn left onto Camperdown Way
- Turn right onto Academy St.
- Cross McBee Ave. and Washington St.
- Building is on the left on the corner of Hampton and Academy Streets

From Spartanburg:

- Take I-85 to I-385 North
- Merge onto I-385 North via Exit 51
- I-385 becomes East North St. as you approach downtown
- Take a right on Academy St. and drive 1.1 miles
- Building is on the right on the corner of Hampton and Academy Streets

From Easley:

- Take U.S. 123 N. to Greenville
- Becomes Easley Bridge Highway/U.S. 123 N.
- Cross Pendleton St. -- becomes S. Academy St./U.S. 123 N.
- Drive about 1.3 miles -- cross Washington St.
- Building is on the left on the corner of Hampton and Academy Streets

From Greer:

- Take Wade Hampton Blvd./U.S. 29 S. to Greenville
- Veer left onto Church St.
- Turn right onto Academy St.
- Cross Buncombe St. -- drive one block
- Building is on the right on the corner of Hampton and Academy Streets

From Laurens and the Golden Strip area:

- Take I-385 into Greenville
- Cross Church St./U.S. 29 (pass Bon Secours Wellness Arena, formerly Bi-Lo Center) - - street name becomes Beattie Pl.
- Cross Main St. -- street name becomes College St.
- Turn left onto Academy St.
- Building is on the right on next block on the corner of Hampton and Academy Streets

From Travelers Rest:

- Take Poinsett Highway/U.S. 276/U.S. 25 south to Greenville
- Becomes Rutherford St.
- Turn left onto Buncombe St.
- Drive a half mile -- turn right onto Academy St.
- Building is on the right on the next block on the corner of Hampton and Academy Streets

*Child's name*_____

*Child's DOB*_____