Center for Hearing & Balance
Bloomsburg University, Dept. of Audiology
400 East 2nd Street
Bloomsburg, PA 17815
570-389-5380

Auditory Processing Disorder Case History

Identifying Information:

Date:_____

Name:_____
First Middle Last

Address:_____
Street Address City State Zip

Phone Number: (____)_____ (____)_____ (____)_____
Home Cell Work

Date of Birth: _____ Age: _____

Referral Source: _____
Name Address

Primary Care Physician: _____
Name Address

Reason for Referral: _____

Family Background:

Father's Name: _____ Age: _____ Occupation: _____
Mother's Name: _____ Age: _____ Occupation: _____
Siblings: _____
Name Age Sex
_____
Name Age Sex
_____
Name Age Sex

Statement of the Problem:

Describe the problem as you understand it:
_____
_____
_____
_____

When was the problem first noticed?_____
Who noted the problem initially? _____
Is there a family history of learning problems? If so please describe in detail:_____
_____

Medical History:

Child's current overall health: _____Good _____Fair _____Poor
Right or Left Handed: _____Right _____Left
Birth History:
Birth Location: _____
Pregnancy and Delivery: _____Normal _____Abnormal
Comments:_____
Newborn Hearing Screening: _____Pass _____Refer _____ Follow-up
Comments:_____

Developmental History: (Please check all that apply)

	Normal	Delayed	Comments
Developmental Milestones			
Fine Motor Skills			
Gross Motor Skills			
Speech and Language Skills			
Neurodevelopmental			

Health History: (Please check all that apply)

		Right	Left	Both	Treatment	Onset/ Most recent occurrence
	Hearing Loss					
	Ear Infection					
	Ear Pain					
	Ear Drainage					
	Ear Pressure					
	Dizziness					

	When	Hospital	Reason
Head Trauma			
Hospitalization			
Surgery			

	List
Allergies	

Professional Diagnosis: (Please check all that apply)

	Attention Deficit Disorder (ADD)
	Attention Deficit Hyperactivity Disorder (ADHD)
	Mental Retardation (MR)
	Autism Spectrum Disorder (ASD)
	Pervasive Developmental Disorder (PDD)
	Asperger's Disorder
	Pervasive Developmental Disorder Not Otherwise Specified (PPD-NOS)
	Learning Disability
	Nonverbal Learning Disorder
	Oppositional Defiant Disorder (ODD)
	Tourette's Syndrome
	Speech Deficit
	Language Deficit
	Visual Perceptual Disorder
	Dyslexia
	Stuttering
	Reading Disorder
	Auditory Processing Disorder (APD)
	Other (Please List)

List professional who diagnosed above disorder/s and when diagnosis was made:_____
_____
_____
_____

Medication:

___ Prescription Medication: Please list or provide a copy of current list

Medication name	Prescribing Physician	Dosage	Purpose

___Non-Prescription Medication: Please list or provide a copy of current list

Non-Prescription Medication	Dosage	Purpose

Academic History:

School: _____
Name Address
Current Grade:_____ Teacher's Name:_____

Classroom: _____Traditional _____Open _____Special Education

Number of students:_____

Preferred Hand: _____Right _____Left

Best Subjects: _____

Description of behaviors/academic difficulties as noted by the school:

_____

_____

_____

_____

_____

Support Services Received through the school or outside sources: (Please check all that apply)

		Description of service	How often are Services Rendered
	IEP		
	504 Plan		
	Title 1		
	Special Education		
	Learning Support		
	Resource Room		
	Classroom Aide		
	Theraputic Support Service Aide (TSS)		
	Assitive Listening Device (FM system)		
	Speech Therapy		
	Occupational Therapy		
	Other		

Additional services received please explain:_____
_____
_____

Evaluations Completed: Please check all that apply

		Findings
	Psychoeducational	
	Receptive Speech and Language	
	Expressive Speech and Language	
	Cognitive Current IQ:_____	
	Neurodevelopmental	
	Psychological	
	Behavioral	
	Vision	
	Visual Perception	
	Other	

Academic Performance: Please check all areas or subjects that the patient has difficulty in school or at home:

	Grapheme (handwriting skills)
	Visual perception – i.e. difficulty copying from the blackboard to his paper
	Reading
	Reading fluency- oral/silent
	Reading comprehension
	Phonemic awareness/sound blending- i.e. confusing words/sounding out words
	Language arts
	Math
	Science/social studies
	Poor attention in quiet
	Following directions auditorily in quiet
	Following directions auditorily in noise
	Following written directions
	Organization of expressive/oral presentations
	Organization of written material
	Organization of everyday materials
	Following simple routines- i.e. bedtime routine
	Utilizing auditory only stimuli
	Utilizing visual only stimuli
	Utilizing visual/auditory stimuli
	Hyperactivity
	Over sensitivity to sound
	Confusion/lost focus in noisy environments
	Poor sleeper
	Behavioral issues

Continue on next page.

Please provide explicit/clear descriptions and examples of *EACH* of the difficulties checked on page 5: Examples are provided below:
i.e. Reading: "He can read; however, he would read a sentence and need to *slowly* sound out each sound of the word in order to read the words" or
i.e. Spelling: "He spells phonetically, for instance, the sentence "tommy is a rough cat" is spelled "tome is a ruf kat" or
i.e. Reading Comprehension: "He reads fast and substitutes words with similar sounding words, so he is unable to comprehend what he is reading."
i.e. Hyperactive: "His teacher indicated that he is often tapping his foot or pencil during class lecture"

Please provide any additional information that you feel may be relevant and beneficial to help this patient:

Provide name and address of person/s who you would like this report sent to, including yourself:

Name	Street Address	City	State	Zip
Name	Street Address	City	State	Zip
Name	Street Address	City	State	Zip

Signature of Person Completing this report

Date