

# CHILDREN'S HEARING HISTORY FORM

*Important: Please answer all questions as completely as possible. This confidential information will guide us in providing the best hearing help for your child.*

Date: \_\_\_\_\_

Referral Source: \_\_\_\_\_

## I. GENERAL INFORMATION

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_  
Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_ OK to leave message? \_\_\_ yes \_\_\_ no  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Employer: \_\_\_\_\_  
Parent/Guardian Occupation: \_\_\_\_\_ Is the child known by any other name than his/her first name? \_\_\_\_\_  
Is child adopted? \_\_\_\_\_ If yes, at what age? \_\_\_\_\_ Pediatrician/Family Doctor: \_\_\_\_\_  
Prior Hearing Evaluation/When/Where: \_\_\_\_\_ Why do you feel your child should have a hearing evaluation? \_\_\_\_\_  
Do you suspect a hearing loss/why? \_\_\_\_\_

## II. BIRTH AND PRENATAL HISTORY

Birth weight \_\_\_\_\_ lb \_\_\_\_\_ oz. Any complications during pregnancy, labor or delivery? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

## III. MEDICAL HISTORY

Of the following diseases, please list which ones your child has had, at what age and the severity: measles, chicken pox, rheumatic fever, mumps, influenza, meningitis, encephalitis, poliomyelitis (for example: measles, age 3, severe),

Does your child have a history of (please circle): seizures, allergies, head injuries, convulsions, colds, high fever, tonsillitis, asthma? \_\_\_\_\_

Did your child ever have a serious physical injury? \_\_\_ yes \_\_\_ no. Nature of injury: \_\_\_\_\_

When? \_\_\_\_\_ Does your child have frequent earaches? \_\_\_ yes \_\_\_ no Which ear? \_\_\_\_\_

Medication?: \_\_\_\_\_ Any medical/surgical treatment for ear/throat problems? \_\_\_ yes \_\_\_ no

Explain: \_\_\_\_\_

Does your child's hearing change day-to-day? \_\_\_ yes \_\_\_ no. Status of hearing today: (please circle) good poor

Has your child ever been to see an ENT Specialist? \_\_\_ yes \_\_\_ no Who/when/why/outcome?: \_\_\_\_\_

Is there any history of hearing loss in your family? (describe) \_\_\_\_\_

## IV. GENERAL DEVELOPMENT

Sit (age) \_\_\_\_\_ Walk (age) \_\_\_\_\_ Toilet Trained (age) \_\_\_\_\_ Right or Left Handed? \_\_\_\_\_

(OVER PLEASE)

## V. AUDITORY BEHAVIOR

Responds to (circle yes or no): **Speech** yes/no; **Car Horn** yes/no; **Vacuum Cleaner** yes/no; **Television** yes/no; **Telephone** yes/no; **Soft Sounds** yes/no; are such sounds responded to consistently? yes/no; Awakened from sleep by sound? yes/no; If child does not respond to sound, do you feel it is because of hearing loss or lack of attention? \_\_\_\_\_

Has your child ever worn hearing aids? yes/no; When? \_\_\_\_\_ Make/Model? \_\_\_\_\_ Ear? \_\_\_\_\_  
How often? \_\_\_\_\_

## VI. SPEECH AND LANGUAGE BEHAVIOR

When did your child first: Babble (age) \_\_\_\_\_ Use first word (age) \_\_\_\_\_ Use first phrase (age) \_\_\_\_\_  
Use first sentence (age) \_\_\_\_\_ How did your child's development of speech compare to that of his/her siblings? \_\_\_\_\_

Did your child ever talk more than he/she does now? yes/no Does your child use words to make wants and needs known? yes/no Does your child use gestures? yes/no Does your child's speech differ from that of others his/her age? yes/no How? \_\_\_\_\_

Has your child ever had speech therapy? yes/no When/where? \_\_\_\_\_  
How long? \_\_\_\_\_ Results: \_\_\_\_\_

## VII. EDUCATIONAL HISTORY

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
How is your child doing in school? (explain) \_\_\_\_\_

## VIII. RELATED INFORMATION

Are any other agencies involved with your child? Who? Why? \_\_\_\_\_

Does your child eat well? yes/no; Sleep well? yes/no; Play with other children? yes/no; Respond well to the family? yes/no Respond well to friends and neighbors? yes/no

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### INSURANCE CLAIM SUBMISSION POLICY EFFECTIVE 8/29/2006

The above signature authorizes Charles A. Reger & Associates, Inc. to file medical claims on behalf of the patient utilizing the private insurance or Medicaid information provided to them. With the rising costs of submitting health care insurance claims, Charles A. Reger & Associates, Inc. has adopted the following policy:

1. An insurance claim will be submitted to the primary insurance carrier (i.e. Medicaid or private insurance company) by Charles A. Reger & Associates, Inc., at the time of the hearing evaluation.
2. Should the claim, if submitted to Medicaid as the primary carrier, not 'roll-over' to the supplemental insurance carrier, the balance of the claim will be the patient's responsibility for resubmission to the supplemental insurance company.
3. Should the claim be rejected due to an error on the part of Charles A. Reger & Associates, Inc. it will be resubmitted by our office at no charge.