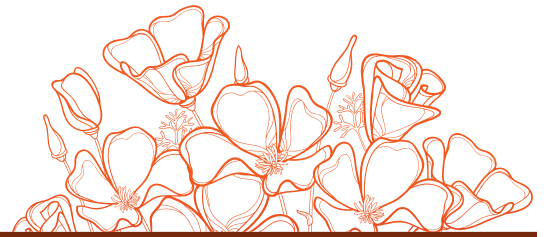


AUDIOLOGY ASSOCIATES

— 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: _____ Secondary 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Maternal illness/infection | <input type="checkbox"/> Lack of oxygen |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cytomegalovirus (CMV) | <input type="checkbox"/> Preeclampsia | <input type="checkbox"/> 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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Emergency cesarean | <input type="checkbox"/> Oxygen administered | <input type="checkbox"/> Phototherapy lights |
| <input type="checkbox"/> Mechanical ventilation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Aminoglycoside antibiotics |
| <input type="checkbox"/> Congenital anomalies | <input type="checkbox"/> NICU stay | <input type="checkbox"/> Meconium aspiration |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Feeding tube | |
| <input type="checkbox"/> Other complications | <input type="checkbox"/> 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 their ears? Yes No

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

Does your child ever complain of pain or fullness in the ears? Yes No

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

If yes, explain _____

Does your child fall or lose balance easily? Yes No

HEALTH HISTORY

Has your child experienced any of the following? If yes, please list the 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 If yes, explain _____

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 child's 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 of Redding 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 child's information regarding his/her hearing and ongoing treatments for the duration of their 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 Associate's 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 Associate's of Redding.