

## **NORTH CAROLINA EYE, EAR, NOSE AND THROAT CLINICS**

4102 ROXBORO RD  
DURHAM, NC 27704

5726 FAYETTEVILLE RD  
SUITE 102  
DURHAM, 27713  
919-287-3443

208 ASHVILLE AVE  
SUITE 10  
CARY, N. C. 27511  
919-859-6771

911-A RIDGE RD  
ROXBORO, NC 27573

336-597-2826

---

Please bring the following items to your Child's Auditory Processing Evaluation:

1. This completed form
2. Any previous evaluations / reports
3. Copy of IEP (if you have one)
4. Copy of 504 plan (if you have one)
5. A snack (breaks will be given as necessary during the testing and often times your child will be hungry)

See you \_\_\_\_\_

9:00 – 11:00 Audiology Portion with Bridget Novey

11:00 – 11:45 Lunch Break (Plenty of places nearby to eat)

11:45 – 2:45 Speech Pathology Portion with Diane Felton

Times are approximate and may be shorter or longer depending upon your child.

If you need to cancel or reschedule please contact Bridget at 919-595-2127. Thank you.

# Auditory Processing Testing Questionnaire

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent Home Phone # \_\_\_\_\_

Parent Work Phone # \_\_\_\_\_

Parent Cell Phone # \_\_\_\_\_

Person completing this form \_\_\_\_\_

Today's Date \_\_\_\_\_

Referring Physician \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # \_\_\_\_\_

Grade \_\_\_\_\_

School \_\_\_\_\_

1. Reason for your child's referral for auditory processing testing and your main concerns:

---

---

---

---

---

---

---

---

---

---

2. What do you hope to learn from today's evaluation? What do you hope to get out of today's evaluation?

---

---

---

---

---

---

---

---

---

---

3. Has your child ever experienced any of the following?

Chronic Ear Infections	Yes	_____	No	_____
Middle ear surgery (tubes)	Yes	_____	No	_____
Frequent Colds	Yes	_____	No	_____
Tonsillectomy	Yes	_____	No	_____
Adenoidectomy	Yes	_____	No	_____
Pneumonia	Yes	_____	No	_____
Meningitis	Yes	_____	No	_____
Allergies	Yes	_____	No	_____
Feeding Disorder	Yes	_____	No	_____
Head Injury	Yes	_____	No	_____
Seizures	Yes	_____	No	_____
Asthma	Yes	_____	No	_____
Encephalitis	Yes	_____	No	_____
Measles/Mumps	Yes	_____	No	_____
High Fevers	Yes	_____	No	_____
Other		_____		_____

4. Did your child pass their newborn hearing screen? \_\_\_\_\_

5. Please describe any other significant medical history, including pregnancy and birth (i.e. significant hospitalizations, was your child full-term, premature, etc).

---

---

---

---

---

---

---

6. Is there a family history of hearing loss or listening problems? If yes, please describe.

---

---

---

---

7. Was your child advanced, age appropriate, or delayed in reaching the following developmental milestones? Please describe any delays your child may have had.

Speech & Language \_\_\_\_\_

Motor \_\_\_\_\_

Feeding \_\_\_\_\_

8. Is your child's performance at grade level, below grade level, or above grade level in the following subjects?

Math \_\_\_\_\_

Spelling \_\_\_\_\_

Reading \_\_\_\_\_

Comprehension \_\_\_\_\_

Written Language \_\_\_\_\_

9. What are your child's academic strengths?

---

---

---

---

---

---

---

10. What are your child's academic weaknesses?

---

---

---

---

---

11. Did your child receive any therapy services (speech-language, developmental, occupational, physical therapy, or reading therapies)? If so when and for how long?

---

---

---

---

12. Has your child had developmental, psychological, or educational testing? If so, when and please describe briefly the findings.

---

---

---

---

13. What are your child's listening difficulties?

---

---

---

---