Auditory Processing Disorder (APD) Case History

Child's Name:_____ Date of Birth:_____
Parent/Guardian:_____ Date of Visit:_____
School:_____ Referred by:_____
Grade:_____ Teacher:_____
Classroom Type: Open Pod_____ Traditional:_____ Portable:_____
Student's preferred hand: Right____ Left____ Language(s) spoken at home:_____
Parent/Guardian email. ***By providing email you consent to us sending you this child's test results via email***:_____

1. Background Information

Please check yes or no to the following questions:

Yes	No	
☐	☐	1. Difficulties during pregnancy/delivery
☐	☐	2. Post natal problems (jaundice, blue baby, transfusions, incubator?)
☐	☐	3. History of ear nose and throat problems (ear infection, allergies…)
☐	☐	4. History of ear tubes or other ear nose and throat surgery?
☐	☐	5. Does your child have hearing difficulties?
☐	☐	6. Has had a hearing assessment. Problems? Yes No
☐	☐	7. Family history of hearing problems?
☐	☐	8. Had significant head trauma? At what age? _____
☐	☐	9. Has had a speech-language assessment?
☐	☐	10. Difficulty with phonics.
☐	☐	11. Has a language problem.
☐	☐	12. Has an articulation (phonology) problem.
☐	☐	13. Performance is below average in one or more subject areas.
☐	☐	14. Has repeated a school year.
☐	☐	15. Has difficulty learning to read.
☐	☐	16. Has poor musical skills
☐	☐	17 Has problem discriminating the difference between certain sounds.
☐	☐	18. Is seen for resource help at school.
☐	☐	19. Has had an educational- psychological evaluation
☐	☐	20. Has had his/her vision tested. Problems? Yes No

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2. Behavior

Please check yes or no to the following questions:

Yes	No	
☐	☐	1. Attention span is not appropriate for age
☐	☐	2. Is impulsive
☐	☐	3. Is disorganized
☐	☐	4. Day dreams, Is easily distracted or inattentive
☐	☐	5. Is sensitive to loud sounds
☐	☐	6. Is easily frustrated
☐	☐	7. Frequently needs instructions to be repeated
☐	☐	8. Forgets what was said in a few minutes
☐	☐	9. Difficulty completing assignments in a timely manner
☐	☐	10. Difficulty getting started on long multi-step assignments
☐	☐	11. Difficulty with multi-part directions
☐	☐	12. Has difficulty hearing conversation when there is background noise
☐	☐	13. Reacts to his own name when there is background noise
☐	☐	14. Gets distracted by surrounding noise (A/C, pencil sharpener, talkers)
☐	☐	15. Appears to localize to sound
☐	☐	16. Often misunderstands what is said
☐	☐	17. Has difficulty understanding people who are speaking at a fast rate
☐	☐	18. Lack of motivation (in general/at school). If yes, provide examples:
☐	☐	19. Visual learner / learns poorly using auditory communication.
☐	☐	20. Disturbs other students in class
☐	☐	21. Is agitated in class
☐	☐	22. Is rejected by the other students
☐	☐	23. Has low self confidence
☐	☐	24. Appears to become tired at school

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Behaviors and Characteristics

Indicate (✓) if your child exhibits any of the following behaviors or characteristics.

- ☐ sensitive to loud sounds
- ☐ appears to be confused in noisy places
- ☐ easily upset by new situations
- ☐ difficulty following and/or understanding TV programs
- ☐ difficulty following directions
- ☐ seeks attention
- ☐ problems sitting still
- ☐ overly active
- ☐ short attention span
- ☐ impulsive
- ☐ easily distracted
- ☐ daydreams
- ☐ forgetful
- ☐ asks for repetition
- ☐ reverses words, numbers, or letters
- ☐ prefers to play with older children
- ☐ prefers to play with younger children
- ☐ prefers solitary activities
- ☐ easily frustrated
- ☐ disruptive or rowdy
- ☐ temper tantrums
- ☐ shy
- ☐ anxiety
- ☐ lacks self-confidence
- ☐ lacks motivation
- ☐ uncooperative
- ☐ disobedient
- ☐ destructive
- ☐ inappropriate social behavior
- ☐ does not complete assignments
- ☐ does opposite of what is requested
- ☐ restless
- ☐ tires easily
- ☐ irritable
- ☐ dislikes school
- ☐ fakes illnesses
- ☐ awkward, clumsy

Please provide additional information to help us understand your child's strengths and weaknesses

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VISION QUESTIONNAIRE

Child's Name:_____ Age:_____ Date: _____

	Does your child suffer from any of the following signs of a potential vision problem? Please assign a value between 0 and 4 for each symptom:	Never or non - existent (0)	Seldom (1)	Occasionally (2)	Frequently (3)	Always (4)
1	Blurred vision at near					
2	Double vision					
3	Headaches associated with near work					
4	Words run together when reading					
5	Burning, stinging, watery eyes					
6	Falling asleep when reading					
7	Vision worse at the end of the day					
8	Skipping or repeating lines when reading					
9	Dizziness or nausea associated with near work					
10	Head tilt or closing one eye when reading					
11	Reading comprehension declining over time					
12	Avoidance of reading and near work					
13	Omitting small words when reading					
14	Writing uphill or downhill (not straight across page)					
15	Mis-aligning digits in columns of numbers					
16	Holding reading material too close					
17	Inconsistent/poor sports performance					
18	Short attention span					
19	Inability to estimate distances accurately					
20	Tendency to knock things over on a desk or table (clumsy)					
21	Misplaces or loses papers, objects, belongings					
22	Car sickness/motion sickness					
	TOTAL SCORE					
	GRAND TOTAL					

Grand total score above "25" or any one question above "3" raises suspicion about a potential visual perceptual issue.