**Speech- Language and Hearing Center**
Northeastern University
*503 Behrakis Health Sciences Center*
*30 Leon Street, Boston, MA 02115*

# CENTRAL AUDITORY PROCESSING EVALUATION
# PARENT QUESTIONNAIRE

Child's Name: ____________________________________________ Date: ________________________

Date of Birth: ____________________ Physician: ___________________________________________
Name of person completing this form: ______________________________________________________

Relationship: ____________________ Phone: _______________________________________________

Child was referred for CAP evaluation by: ___________________________________________________

Why was your child referred for a CAP evaluation? ____________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

What do you hope to learn from this evaluation? ______________________________________________

______________________________________________________________________________________

## EDUCATIONAL HISTORY

Child's school/town: _____________________________Grade:__________________________________

Has your child repeated a grade? _____If yes, which grade(s) was repeated? _______________________

What type of classroom is your child in? _____open ____traditional ____ substantially separate

My child is on a ____ IEP ____ 504 Plan ____ no special services or accommodations.

Does your child have a FM or soundfield listening system? _____ yes ______ no

Briefly describe the class (e.g. # if children, teachers, aides, unusual physical characteristics):
______________________________________________________________________________________
______________________________________________________________________________________

Is your child having problems with:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Phonics | ____ | ____ | Writing | ____ | ____ |
| Reading Comprehension | ____ | ____ | Spelling | ____ | ____ |
| Math | ____ | ____ | Social Studies | ____ | ____ |
| Science | ____ | ____ | Language Arts | ____ | ____ |
| Foreign Language | ____ | ____ | Speech | ____ | ____ |
| Social Skills | ____ | ____ | Memory | ____ | ____ |
| Organizational Skills | ____ | ____ | Attention | ____ | ____ |

(Please describe on next page)

Comments: ___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Check services/accommodations child receives and indicate, where appropriate, how often services are received each week.

Resource Room_______________________________________________________________
Speech-Language Therapy: ____________________________________________________
Occupational Therapy: _______________________________________________________
Physical Therapy: ___________________________________________________________
Counseling: _________________________________________________________________
Classroom Aide: _____________________________________________________________
ModifiedCurriculum/Instruction: ______________________________________________
Extra Time for Tests:
Assistive Listening Device: ____________________________________________________
Other (Please describe):_______________________________________________________

## EVALUATION HISTORY:

Check evaluations your child has received and indicate the date and results of evaluation.
**Copies of reports must be returned with this form.**

Hearing Evaluation: Yes: ___ No: ___ Date/location: ___________________________________
Results: ___________________________________________________________________

CORE Evaluation: Yes: ___ No: ___ Date/location: _____________________________________
Results: ___________________________________________________________________

Cognitive (IQ) Testing: Yes: ___ No: ___ Date/location: ________________________________
Test: (circle one) WISC-III WISC-R Stanford Binet Other
Results (if known): verbal: ______ performance: ______ full scale: _______

Psychosocial/Emotional Assessment: Yes: ___ No: ___ Date/location: _______________________
Results: ___________________________________________________________________

Speech-Language Evaluation: Yes: ___ No: ___ Date/location: ____________________________
Results: ___________________________________________________________________

Neurological Evaluation: Yes: ___ No: ___ Date/location: _______________________________
Results: ___________________________________________________________________

## MEDICAL HISTORY:

Were there any problems during pregnancy, labor or delivery with this child? Yes: ____ No: _____
If yes, please describe. _______________________________________________________

Has your child had any serious illness or injuries? Yes: ____ No: _____
If yes, please describe. _______________________________________________________

Does your child have a history of seizures? Yes: ____ No: _____
If yes, please describe. _______________________________________________________

Is your child currently taking any medications? Yes: ____ No: _____
If yes, please describe. _______________________________________________________

Has your child experienced episodes of otitis media (fluid, ear infection)? Yes: ____ No: _____
If yes, how many and last episode: ______________________________________________________

Has your child been seen by an ENT physician (ear specialist)? Yes: ____ No: _____
If yes, indicate physician and reason: ____________________________________________________

Has your child ever had tubes placed in the ears? Yes: ____ No: _____
If yes, please describe. ______________________________________________________________

Does your child have a hobby that exposes him/her to loud noise, such as shooting, motor sports (snowmobiles, motorbikes e.g.), musical instrument, use of personal music device such as an iPod? Yes: ____ No: ______ Please describe: ______________________________________________
_________________________________________________________________________________

Has your child ever been diagnosed with an attention problem? Yes: ____ No: _____
If yes, is your child on medication (please indicate medication):_____________________________

Has your child been identified with ____ autism ____ PDD (Pervasive Developmental Delay) ____ mental retardation ____ a genetic disorder or _____ an anxiety disorder? If so, please describe:
_________________________________________________________________________________
_________________________________________________________________________________

Do any family members have a history of speech-language difficulties, learning difficulties or motor disorders? Yes: ___ No: ____
If yes, please describe: _______________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Are there family members who have a history of hearing loss that started before age 30 (or at birth)? Yes ____ No ____. If yes, please detail the family relationship and any known details regarding the type of hearing loss:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

## DEVELOPMENTAL/SPEECH-LANGUAGE/AUDITORY HISTORY:

Child's primary language: _____________________________________________________________

Has your child been exposed to another language on a regular basis? Yes: ___ No: ___
Please describe: __________________________________________________________________

At what age did your child first: sit up: ___ crawl: ___ walk: ___ say first words: ___
combine words: ___ speak in sentences:___

Has your child ever received speech and/or language therapy? Yes ___ No: ____ if so, at what age and through what provider? _______________________________________________________________
___________________________________________________________________________________

Does your child have an articulation problem or is her/his speech difficulty to understand?
Yes: ___ No: ___

Is your child's language grammatically incorrect? Yes: ___ No: ___

Does your child misunderstand the content of stories, TV shows, and movies? Yes: ___ No: ___

Does your child confuse sounds or misunderstand what is said to him/her? Yes: ___ No: ___

Does your child have difficulty following multiple step directions? Yes: ___ No: ___

Does your child have difficulty engaging in conversation (explaining ideas, maintaining topic, organizing a story in logical order)? Yes: ___ No: ___

Does your child misunderstand jokes or riddles? Yes: ___ No: ___

Are you concerned about your child's hearing? Yes: ____ No: ____

Does your child have trouble hearing in noise or in group situations? Yes: ____ No ____

Does your child mishear communications? Yes: ____ No: ____

Does your child have difficulty remembering what is said? Yes: _____ No: ______

Does your child respond in a delayed manner to communications or questions? Yes: ____ No: ____

If you answered YES to any of the above, please describe or provide examples/comments (please use reverse if you need further space): ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## EMOTIONAL STATUS:

Do have any concerns regarding your child's emotional development? Yes: ___ No: ___
If yes, please describe: ____________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

## ADDITIONAL COMMENTS:

Please add any comments that would help us understand your child.
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What questions would you like us to address during this evaluation?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

*****Please remember, reports of previous evaluations (e.g. speech-language, academic, neuropsychological) you have listed under the evaluation history section on page 2, must be returned with this form before an appointment is scheduled.**