# 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:

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(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.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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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.