Northeastern University
Bouvé College of Health Sciences
Speech Language and Hearing Center

Pediatric Auditory Processing Evaluation Intake Form

Child's Name: _____ Date of Birth: _____

Name of person completing this form:_____ Relationship to the child:_____

Address:_____

Telephone: _____ Email: _____

Today's Date: _____

Who referred the child for this evaluation? _____ Telephone: _____

Area(s) of concern:

_____

_____

_____

OTOLOGICAL HISTORY:

Has your child experienced episodes of Otitis Media (ear infections)? Yes No
If yes, briefly describe the frequency of episodes and indicate the date of the most recent episode.

Has your child been seen by an ENT physician? Yes No
If yes, please indicate the name of physician and how often seen

Has your child had tubes placed in the ears? Yes No
If yes, list date(s):

Does your child have any medical diagnoses? Yes No
If yes, please indicate:

MEDICAL – DEVELOPMENTAL HISTORY:

Department of Communication Sciences & Disorders Bouvé College of Health Sciences
503 Behrakis Health Sciences Center
360 Huntington Avenue
Boston, MA 02115

617-373-2492
617-373-8756 FAX
SLHC@northeastern.edu.

Was your child born: Full Term ____ or Premature ____
If you answered premature, what was the length of pregnancy?

Describe any complications or concerns during pregnancy or childbirth:

Did your child stay in the NICU for any period of time after birth? Yes No
If yes, please describe why, and how long was the stay was.

Are there any immediate family members who have a diagnosis of an auditory processing disorder? Yes No
If yes, please list who?

Did your child meet developmental milestones on schedule? Yes No
If no, please explain:

Does your child have a chronic illness or disease? Yes No
If yes, please explain:

Please list all medications your child is currently prescribed:

Please share any other pertinent medical information:

Please describe any concerns that you have about your child's development:

Does your child present with articulation difficulties (e.g.,speech is difficult to understand? Yes No
If yes, please describe:

Does your child misunderstand what is said? Yes No
If yes, please describe:

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Does your child have difficulty following multi-step directions? Yes No
If yes, please describe:

Is your child easily distracted? Yes No

Does your child say "what" or "huh" frequently? Yes No

Does your child seem confused by multiple instructions? Yes No

Does your child forget what is said in a few minutes? Yes No

Does your child confuse similar words or sounds? Yes No

Does your child have spelling, reading, writing difficulties? Yes No

Do you often repeat directions to your child? Yes No

Is your child easily frustrated? ____ Yes No

Is your child hyperactive? Yes No

Educational History:

Child's School's Name: _____ Grade: _____
School's address: _____

Has your child ever repeated any grades? Yes No
If yes, why:

Does your child have an IEP or 504 Plan? Yes No
If yes, please send this in prior to the AP evaluation.

Is your child having difficulties with:
Phonics Yes No Reading Comprehension Yes No

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Writing	Yes	No	Foreign Language	Yes	No
Spelling	Yes	No	Social Studies	Yes	No
Math	Yes	No	Science	Yes	No

Evaluation History:

Has your child ever had a CORE Evaluation? Yes No

Has your child had Cognitive (IQ) testing? Yes No

If yes, please send in full report, as **this information is necessary to determine if your child meets the cognitive criteria for AP testing.**

Has your child had a Speech-Language Evaluation? Yes No

If yes, please send in the full report, as **this information is necessary to determine if your child meets the language criteria for AP testing.**

Additional Comments:
Please add any comments that would help us better understand your child:

Are there any questions that you would like to have us address during this evaluation?

Date Evaluation has been scheduled: _____
Approval/comments: _____

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