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

Adult Central Auditory Processing Evaluation Intake Form

Patient's Name: _____ Date of Birth: _____

Name of person completing this form:_____ Relationship to the patient:_____
Address:_____

Telephone: _____ Email: _____

Today's Date: _____

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

Area(s) of concern:

_____

_____

_____

Have you had a recent hearing evaluation? __ Yes __ No
If yes, was your hearing normal? __ Yes __ No
If no, please explain.

Please send a copy of your most recent audiological evaluation when you return this completed form.

Have you ever had tubes placed in the ears? __ Yes __ No
If yes, list date(s):

Do you have any medical diagnoses? __ Yes __ No
If yes, please indicate:

Medical and Developmental History:

Primary language:

Did you reach your developmental milestones on time? __ Yes __ No
If no, please describe:

Did you have a history of articulation or speech language difficulties? __ Yes __ No
If yes, please describe:

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503 Behrakis Health Sciences Center
360 Huntington Avenue
Boston, MA 02115

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

Do you ever misunderstand what is being said (spoken language/speech)? __ Yes __ No
If yes, please describe:

Did you ever have any serious illnesses or accidents or head injuries? __ Yes __ No
If yes, please describe.

Family History:

Is there a family history of learning problems, ADHD, Central Auditory Processing Disorder? __ Yes __ No
If yes, please explain.

Present Information:

What behaviors or symptoms make you suspect that you may have an auditory processing disorder?

Behaviors/Symptoms: *(Please check the ones that apply to you)*

- ❑ Difficulty hearing
- ❑ Difficulty following conversation on the telephone
- ❑ Frequently say "huh" or "what"
- ❑ Difficulty remembering multiple instructions/sequential commands
- ❑ Difficulty following directions
- ❑ Difficulty following long conversations
- ❑ Forget what was said after a few minutes
- ❑ Often misunderstand what is said
- ❑ Confuse similar words or sounds
- ❑ Easily distracted by background sounds
- ❑ Have a short attention span
- ❑ Lack of music appreciation
- ❑ Difficulty taking notes
- ❑ Difficulty learning a foreign language or technical information where language is novel or unfamiliar
- ❑ Social issues—difficulty "reading" others/pragmatic communication issues
- ❑ Spelling, reading, writing issues.

Have you ever been diagnosed with an attention deficit disorder? __ Yes __ No
If yes, please explain and share when you received the diagnosis?

- Do you take medication for it? Please list.
- What is the dosage of medication and how often is it taken?
- How long have you been taking this medication?

Is there any other medical information that you think would be beneficial for us to know?

Educational History:

Did you ever repeat any grades? __ Yes __ No
If yes, please explain why.

Did you have an IEP or 504 Plan? __ Yes __ No
If yes, please explain and share any documents.

What is the highest grade that you completed?

Did you have problems with the following in school?

Phonics	Yes	No	Reading Comprehension	Yes	No
Writing	Yes	No	Foreign Language	Yes	No
Spelling	Yes	No	Social Studies	Yes	No
Math	Yes	No	Science	Yes	No

Work History:
What is your vocation?

How do your symptoms impact your ability to be successful at work?

Evaluation History:

Did you ever have Cognitive (IQ) testing? __ Yes __ No
If yes, please send in a copy of this testing**.**

Did you ever have a Speech-Language Evaluation? __ Yes __ No
If yes, please send in the full report**.**

Did you ever have an Auditory Processing Evaluation? __ Yes __ No
If yes, please send in the full report or explain.

Additional Comments:

Please share any additional information that would help explain your concerns.

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

To Be Completed by the Audiologist:

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

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