



**Blue Ridge Speech & Hearing Center**  
**19465 Deerfield Avenue, Suite 201**  
**Lansdowne, VA 20176**  
**703-858-7620 703-858-7657 FAX**  
**www.speechhearing.org**

**LCPS Pediatric Case History Form (Audiology)**

<b>Name:</b>	_____	<b>Date:</b>	_____
<b>Address:</b>	_____	<b>Sex:</b>	_____
	_____	<b>Date of Birth</b>	_____
<b>Home Phone:</b>	_____	<b>Age:</b>	_____
<b>Cell Phone:</b>	_____	<b>Referred by:</b>	_____
<b>Email Address:</b>	_____	<b>Pediatrician:</b>	_____

**Ethnicity:** \_\_\_\_\_ African American \_\_\_\_\_ Asian \_\_\_\_\_ Caucasian  
 \_\_\_\_\_ Hispanic / Latino \_\_\_\_\_ Other: \_\_\_\_\_

<b>Father's Name:</b>	_____	<b>Mother's Name:</b>	_____
<b>Father's Address:</b>	_____	<b>Mother's Address:</b>	_____
	_____		_____
<b>Fathers' Employer:</b>	_____	<b>Mother's Employer:</b>	_____
<b>Father's Position:</b>	_____	<b>Mother's Position:</b>	_____
<b>Work Phone:</b>	_____	<b>Work Phone:</b>	_____
<b>E-Mail Address:</b>	_____	<b>E-Mail Address:</b>	_____

**Parental Marital Status:** \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

**Combined Income (Please check one)**

_____ \$12,000-\$20,000	_____ \$40,000-\$60,000	_____ \$80,000-\$100,000	_____ Over \$120,000
_____ \$20,000-\$40,000	_____ \$60,000-\$80,000	_____ \$100,000-\$120,000	

**How did you hear about us? (Please check all that apply)**

_____ Word of mouth	_____ Phone book / Yellow Pages	_____ School system
_____ Internet	_____ Physician	_____ Other: _____

If you **do not** want to receive information about new services, fundraising events or other Blue Ridge Speech and Hearing news, please check here.  
 \_\_\_\_\_

**Statement of Problem**

1. Reason for referral from LCPS: \_\_\_\_\_ Could not condition to task  
 \_\_\_\_\_ Failed hearing screening with Child Find  
 \_\_\_\_\_ Failed a hearing screening in school  
 \_\_\_\_\_ Child has a known hearing loss
2. Do you have concerns regarding your child's hearing? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - a. If yes, list examples of what concerns you: \_\_\_\_\_
3. Has he/she ever worn a hearing aid? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - a. If yes, at what age were they fit with hearing aids? \_\_\_\_\_
  - b. Make and Model of hearing aids: \_\_\_\_\_

4. Does your child have *extreme* reactions to new situations? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_
5. Does your child have any hyper-sensitivities? (sound, touch, light, etc)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_

**Medical History**

6. Was he/she premature? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, how many weeks premature? \_\_\_\_\_
7. Was your child ever placed in the NICU (neonatal intensive care unit)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, why? \_\_\_\_\_
8. Were there any abnormalities noted at birth? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_
9. **Did your child pass his/her newborn hearing screening?** \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. What hospital has he/she born at? \_\_\_\_\_
10. Is your child currently on any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, what medication and what is the reason for taking? \_\_\_\_\_
11. Has your child had more than one middle ear infection? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, how many? \_\_\_\_\_  
 b. If yes, when was his/her last ear infection? \_\_\_\_\_  
 c. If yes, how have the ear infections been treated? \_\_\_\_\_
12. Does your child suffer from seasonal allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No
13. Do you notice any imbalance/dizziness/vertigo? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_
14. Has your child had illness with high fevers? \_\_\_\_\_ Yes \_\_\_\_\_ No
15. Has your child had surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_
16. Please list any developmental delays in which you are concerned: \_\_\_\_\_
17. Additional Comments: \_\_\_\_\_

**Family History**

18. Is there any history of hearing loss or deafness in the family? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_
19. Do you have any other children with speech and/or hearing problems? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_

**Educational History (if currently enrolled in school only)**

20. What grade are they in school: \_\_\_\_\_
21. Is he/she enrolled in Special Education? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_
22. Do any subjects cause particular difficulty? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 a. If yes, please explain: \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Statement of Release

I,   
**Your name here**

hereby request and/or grant permission to the above named Clinic to send a report of the diagnostic findings, evaluation, and therapy progress of this case to the following:

**Pediatrician:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
FAX: \_\_\_\_\_

**ENT:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
FAX: \_\_\_\_\_

**Audiologist:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
FAX: \_\_\_\_\_

**Neurologist:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
FAX: \_\_\_\_\_

**School:** Name: Loudoun County Public Schools  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Patient:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
FAX: \_\_\_\_\_