Central Auditory Processing History Questionnaire

This form is to be completed along with the Pediatric Hearing Health History form.
Please bring both with you to your appointment.

Child's Name: ______________________ Date of Birth: ______________

Pediatrician: ______________________ Age & Grade: ______________

Who recommended the CAP evaluation? ______________________

Why has this evaluation been recommended? ______________________

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Which school does your child attend? ______________________

What other medical evaluations has your child had? ______________________

Does your child receive extra help in school or services such as speech therapy or occupational therapy?

____

Is your child's native language English? ☐ yes ☐ no

If not, what is the native language? ______________________

Is there a family history of learning difficulties? ☐ yes ☐ no

If so, please explain: ______________________

What subjects does your child excel at? ______________________

What subjects does your child struggle with? ______________________

Does your child experience any of the following? (please check all that apply):

- ○ anxiety
- ○ depression
- ○ difficulty listening in noisy environments
- ○ difficulty following directions
- ○ behavioral issues

Does your child tend to tire or become frustrated easily? ☐ yes ☐ no

If yes, please describe: ______________________

Please list any medications your child is currently taking: ______________________

What medical or psychological diagnoses does your child have? ______________________

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What are your expectations for today's evaluation? ______________________

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Signature of Person
Providing Information: ______________________ Date: ______________