Adolescent Case History (6-18)

Patient Information

Name: _____ Responsible Party: _____

Birthdate: _____ Gender: Male Female Other Preferred Phone: Home Mobile Work

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

E-mail Address: _____ Work Phone: _____

Marital Status: _____ Employment Status: _____ Student Status: _____

Primary Language: _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino Race: _____

Guardian/Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Reason for Visit

Chief Complaint: (Check all that apply)

___ Difficulty Hearing – Right Left Both

___ Tinnitus/Ringing – Right Left Both

___ Dizziness/Vertigo

___ Auditory Processing

___ Failed Hearing Screening

___ Other _____

How long have you noticed this difficulty? _____

Hearing History

Has the patient ever had a hearing test? No Yes – When and Where: _____

Do you feel the patient's hearing is changing? No Yes – Gradually Suddenly Fluctuating

What do you think is the cause of the patient's hearing loss? _____

_____

Which ear does the patient use to talk on the phone? Right Left Both

Auditory Problems Checklist: (Check all that apply to the patient)

___ 1. Has a history of hearing loss

___ 2. Has a history of ear infections

___ 3. Does not pay attention (listen) to instruction 50% or more of the time

___ 4. Does not listen carefully to directions-often necessary to repeat instructions

___ 5. Says "huh" and "what" at least five or more times per day

Auditory Problems Checklist (continued): (Check all that apply to the patient)

___ 6. Cannot attend to auditory stimuli for more than a few seconds

___ 7. Has a short attention span (If this item is checked, check appropriate time frame)

__ 0-2 minutes __ 2-5 minutes __ 5-15 minutes __ 15-30 minutes

___ 8. Daydreams, attention drifts, not with it at times.

___ 9. Is easily distracted by background sound(s).

___ 10. Has difficulty with phonics

___ 11. Experiences problems with sound discrimination

___ 12. Forgets what is said in a few minutes

___ 13. Does not remember simple routine things from day to day

___ 14. Displays problems recalling what was heard last week, month, year

___ 15. Has difficulty recalling a sequence that has been heard

___ 16. Experiences difficulty following auditory directions

___ 17. Frequently misunderstands what is said

___ 18. Does not comprehend many words – verbal concepts for age/grade level

___ 19. Learns poorly through the auditory channel

___ 20. Has a language problem (morphology, syntax, vocabulary, phonology)

___ 21. Has an articulation (speech) problem

___ 22. Cannot always relate what is heard to what is seen

___ 23. Lacks motivation to learn

___ 24. Displays slow or delayed response to verbal stimuli

___ 25. Demonstrates below average performance in one or more academic areas

Does the patient currently wear hearing aids? No Yes - Right Left Both

Please circle any types of loud noise the patient has been exposed to, either recently or in the past:

Farm Machinery Hunting/Shooting Loud Headphones Music

Other: _____

Is there a history of hearing loss in your family? No Yes – Who? _____ Cause? _____

Has the patient seen an Ear, Nose and Throat Physician? No Yes

If yes, who did they see?_____ When? _____

Any history of, or active drainage from, the ear within the past 90 days? No Yes

If yes, please describe: _____

Has the patient experienced any recent pain or discomfort in the ear? No Yes

If yes, please describe: _____

Has the patient, in the past 90 days, experienced chronic or acute dizziness, lightheadedness, or vertigo? No Yes

If yes, please describe: _____

Medical History

Please circle any of the following that you currently have or have had in the past:

AIDS	Diabetes-Insulin Y/N	High Blood Pressure	Measles	Tonsillitis
Anemia	Diabetes-Type 1 or 2	High Cholesterol	Meningitis	Tooth Decay
Anxiety	Diphtheria	High Fevers	Mumps	Typhoid
Appetite Change	Encephalitis	HIV	Neurological Symptoms	Vascular Problems
Asthma	Fatigue	Influenza	Obesity	Worry
Bell's Palsy	Genetic Disorders	Kidney Disease-Stage __	Scarlet Fever	Other: _____
Blood disorders	Headaches	Loneliness	Sinusitis	
Cancer	Head Injury	Lung Disease	Stroke	
Chicken Pox	Heart Problems	Malaise	Thyroid Disease	
Depression	Hepatitis	Malaria	TIA	

Please check all medical symptoms that apply:

_____ Eye problems (such as blurred vision, pain) _____

_____ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain) _____

_____ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations) _____

_____ Respiratory Symptoms (such as shortness of breath, cough, wheezing) _____

_____ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain) _____

_____ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma) _____

_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness) _____

_____ Psychiatric Issues (such as depression, anxiety, compulsions) _____

_____ Endocrine Symptoms (such as frequent urination, hot flashes) _____

_____ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands) _____

_____ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency) _____

Any history of significant illnesses, surgeries, injuries or hospitalizations: _____

_____

Do you take any prescription or over-the-counter medications? No Yes

If yes, please provide a list at check-in.

Please list any allergies:

___ Food _____

___ Medications _____

___ Plastic _____

___ Metals _____

___ Other _____

Primary Insurance Information (If patient is the insured, enter 'SAME' for name & address)

Insurance Company Name: _____

Insured's Name: _____

Address: _____

Patient Relation to Insured (circle one) Self Spouse Child Other _____

Subscriber ID Number (Member ID): _____Insurance Group Number: _____

Secondary Insurance Information (If patient is the insured, enter 'SAME' for name & address)

Insurance Company Name: _____

Insured's Name: _____

Address: _____

Patient Relation to Insured (circle one) Self Spouse Child Other _____

Subscriber ID Number (Member ID): _____Insurance Group Number: _____

Please list all the ways you heard about us: _____

By signing below, I consent for my child to receive audiological services at All Generations Audiology, PLLC. The consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent form will be valid and remain in effect as long as my child receives audiological care at All Generations Audiology, PLLC.

Signature: _____ Date: _____

Relationship if not signed by patient (i.e. guardian, POA, etc.) _____