Communication Sciences and Disorders
Speech-Language and Hearing Clinics
516 High Street | MS 9171 | Bellingham, WA 98225
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Audiology Clinic: Pediatric Client Intake Form

Client Information

Legal first name: Legal last name:

Preferred or lived name: Pronouns:

Date of Birth: Preferred language(s):

Mailing Address:

City: State: Zip:

Primary Care Provider/Doctor:

Parent/Guardian 1

Name: Date of Birth:

Relation to Child: Preferred language(s):

Phone: Mobile Carrier:

Email address:

Parent/Guardian 2

Name: Date of Birth:

Relation to Child: Preferred language(s):

Phone: Mobile Carrier:

Email address:

Emergency Contact:

Emergency Contact Name:
Emergency Contact Relationship:
Emergency Contact Phone:
Emergency Contact Email:

Please describe any parent or guardian restrictions, such as parenting plan or custody agreement:

Audiology Clinic: Pediatric Client Case History

1. Reasons for visit (mark all that apply):
   - ☐ I am concerned about my child's hearing
   - ☐ My child's doctor, teachers, or others have concerns
   - ☐ My child failed a hearing screening
   - ☐ My child has a speech delay or other developmental concern
   - ☐ My child has risk factors for hearing loss
   - ☐ Other:

2. Did your child pass their newborn hearing screenings? ◯ yes ◯ no ◯ unknown
   If no or unknown, please explain:

3. Do you think your child has a hearing problem? ◯ yes ◯ no ◯ unsure
   If no or unsure, please explain:

4. How does your child respond to sounds at home? (mark all that apply)
   - ☐ Startles at loud sounds
   - ☐ Notices alarms or alerts such as sirens, car alarms, doorbells, etc.
   - ☐ Looks or turns toward the source of a sound
   - ☐ Hears you call from another room

5. Does your child do any of the following? (mark all that apply)
   - ☐ Turns up the volume on devices, or asks for the volume to be turned up
   - ☐ Reads lips
   - ☐ Watches faces intently
   - ☐ Struggles to understand or follow directions (compared to similar ages)
   - ☐ None of the above

6. Does your child have family history of hearing loss before age 50? ◯ yes ◯ no ◯ unknown
   If yes, please list family members, their relationship, and any known diagnoses.

4. Does your child have a history of head trauma? ◯ yes ◯ no ◯ unknown
   Examples: concussions, skull fractures, or other head injuries
   If yes, please describe:

5. Has your child had ear surgery? ◯ yes ◯ no ◯ unknown

If yes, which ears? ◯ right ◯ left ◯ both

Date(s) and type(s) of surgery:

6. Does your child have a history of ear infections? ◯ yes ◯ no ◯ unknown

If yes, which ears? ◯ right ◯ left ◯ both

When did they first occur?

How frequently have they occurred?

When was the most recent infection?

7. Has your child had tubes placed in their eardrum(s)? ◯ yes ◯ no ◯ unknown

If yes, which ears? ◯ right ◯ left ◯ both

8. Does your child have any health problems or concerns? ◯ yes ◯ no

If yes, please list or describe:

9. Please list any medications or supplements your child is taking:

10. Were there any complications during pregnancy? ◯ yes ◯ no ◯ unknown

Examples: maternal illness, injury, or infections or exposure to drugs or radiation

If yes, please describe:

11. Were there any complications during the delivery or birth? ◯ yes ◯ no ◯ unknown

Examples: long labor, C-section, use of forceps, premature membrane rupture

If yes, please describe:

12. Please select any of the following that apply or applied to your child:

- ☐ Low birthweight (less than 1500 grams or 3.3 lbs)
- ☐ Low Apgar score (4 or less at one minute, 6 or less at five minutes)
- ☐ Low Intrauterine Growth Rate (5% or less)
- ☐ Mechanical ventilation (more than 5 days)
- ☐ Craniofacial or skeletal abnormalities
- ☐ Cleft lip or palate
- ☐ Jaundice/hyperbilirubinemia
- ☐ Ototoxic medications (gentamycin, vancomycin, etc.)
- ☐ Intracranial bleeding or other CNS abnormality
- ☐ Bacterial meningitis
- ☐ Congenital perinatal infections (CMV, toxoplasmosis, HIV, herpes, rubella)

13. Has your child met all developmental milestones for their age? ◯ yes ◯ no

If no, please explain:

14. Are you, doctors, or others concerned about your child's development? ◯ yes ◯ no

If yes, please explain:

15. Do you think or know that your child has a speech or language delay? ◯yes ◯no

If yes, please explain:

16. Anything else we should know?

The next page has optional questions intended for children under 6 and children with special needs.

Signature of parent or guardian **Date:**

Additional Questions

The following questions are for children under 6 as well as children with special needs. Your answers help us select the tests, activities, and strategies that are most likely to be successful. Our goal is to create an environment as free from stress as possible for both you and your child.

What are your child's current interests?

What toys does your child currently enjoy?

What are your child's favorite songs or games?

Is your child motivated by prizes? If not, what does motivate your child?

How does your child typically do at the doctor or dentist?

Does your child tolerate their ears being touched?
If not, getting your child used to this can help the hearing test so smoothly.

What puts your child at ease?