

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? _____

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? _____

What are your expectations for today's evaluation? _____

Signature of Person

Providing Information: _____ Date: _____