

Child's Name:	Date:	
Date of Birth:	Sex: ☐ M ☐ F	
HEARING		
	NO	YES
Are you concerned about your child's hearing?	☐	☐
Does your child ask for frequent repetition?	☐	☐
Does your child seem to mis-hear or seem to ignore you?	☐	☐
Does your child startle to loud noises?	☐	☐
Does your child respond when his/her name is called?	☐	☐
Did your child pass the newborn hearing screening?	☐	☐
SPEECH & LANGUAGE		
	NO	YES
Do you have concerns about your child's speech development? If yes, please describe your concerns: _____ _____	☐	☐
EXPRESSIVE VERBAL LANGUAGE		
	NO	YES
Has your child been diagnosed with speech delay?	☐	☐
If your child is verbal, at what age did your (s)he say their first words? _____	☐	☐
If your child is over 2 years old, is (s)he combining words and using simple 2 or 3 word phrases?	☐	☐
Is your child's speech easy to understand by people other than family members?	☐	☐
Has your child been assessed by a speech pathologist?	☐	☐
If your child is not talking yet, does (s)he try to use non-verbal gestures such as pointing to express their needs?	☐	☐

COMPREHENSION		
	NO	YES
Does your child have difficulty understanding simple instructions?	☐	☐
Does your child have difficulty remembering instructions?	☐	☐
BEHAVIOURAL/SOCIAL		
	NO	YES
Does your child enjoy playing games, singing and laughing with you?	☐	☐
Does your child display joint attention and make consistent and deliberate eye contact with you?	☐	☐
Does your child seek you for consolation when (s)he is hurt or upset?	☐	☐
Does your child show affection (i.e. likes to be hugged, kissed, tickled, smiles)?	☐	☐
Does your child show interest in other people?	☐	☐
Does your child enjoy playing with toys, story books and songs, etc.?	☐	☐
EDUCATION		
	NO	YES
Do you or teachers/educators have concerns about your child's academic development? If yes, please explain: _____	☐	☐
Does your child have difficulty with reading, writing and spelling?	☐	☐
Does your child have difficulty following multi-step instructions?	☐	☐
Does your child have difficulty remembering verbal instructions?	☐	☐
Has your child ever had a psychoeducational assessment?	☐	☐
FAMILY HISTORY		
	NO	YES
Do any first-degree relatives (parents and siblings) or second-degree relatives (grandparents, uncles/aunts) have a hearing loss diagnosed childhood?	☐	☐
Do any first-degree or second-degree relatives have a history of progressive blindness? If yes, please specify: _____	☐	☐

PREGNANCY & BIRTH		
	NO	YES
Did the mother use any street drugs, prescription medications (including antibiotics) or other chemical substances during pregnancy? If yes, specify: _____	☐	☐
Did the mother consume alcohol during pregnancy?	☐	☐
Did the mother use tobacco or other nicotine containing substances?	☐	☐
Was the mother exposed to radiation / chemotherapy during pregnancy?	☐	☐
During pregnancy, was the mother diagnosed with: ☐ Syphilis ☐ Herpes ☐ Influenza ☐ HIV/AIDS ☐ Toxoplasmosis ☐ Other: _____		
Did the pregnancy proceed with to full term? If no, how many weeks early: _____	☐	☐
Was labour induced? If yes, please provide reason: _____	☐	☐
Were there any complications during labour and delivery? If yes, specify: _____	☐	☐
NEONATAL HISTORY		
	NO	YES
What was your child's birth weight? _____		
Were the APGAR scores low at birth?	☐	☐
Did your child require oxygen after delivery? If yes, for how long? _____	☐	☐
Was your child admitted to intensive care?	☐	☐
Did your child require ECMO (extracorporeal membrane oxygenation)?	☐	☐
Was your child jaundiced? If yes, was light therapy administered? ☐ Yes ☐ No	☐	☐
Does your child have defects of the ears and/or clefting of the lip and palate:	☐	☐
Was your child diagnosed with a syndrome? If yes, for how long? _____	☐	☐
Does your child have a heart defect?	☐	☐

INFANT/CHILDHOOD HISTORY

	NO	YES
Has your child ever had a serious head injury?	☐	☐
During pregnancy, was the mother diagnosed with:	☐ Mumps ☐ Measles ☐ Meningitis ☐ CMV	

EAR HEALTH HISTORY

Ear Infections: ☐ None ☐ Left ☐ Right ☐ Both

If any, specify what ages, how many, and how often:

If any, when was the last ear infection?

Ever had "tubes" in ears? ☐ None ☐ Left ☐ Right ☐ Both

If yes, specify when and how many times:
