PROFESSIONAL
HEARING CENTER
A Division of Ascentist Physicians Group LLC

CASE HISTORY - ADULT

Identifying Information

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Age_____ Birthdate____/____/____ Gender M F Handedness R L A

Home Phone_____ Work Phone_____

Email_____ Occupation_____

Other Contact: Name_____Phone_____

Who referred you?_____

Reason_____

Background Information

Reason for testing (please check all that apply):

☐Work related
☐School related
☐Hearing problem
☐Speech-Language issues
☐Social difficulties
☐Emotional state

What problem(s) have been noted that makes an Auditory Processing problem a concern?

_____

_____

_____

When was this first noticed?_____

Under what conditions has it been noted?_____

Has problem gotten worse?☐ yes ☐no ☐don't know Was onset ☐sudden ☐gradual

Was onset associated with an incident/factor? ☐yes ☐no ☐don't know What incident?_____

_____

What would you like to get from this evaluation?_____

_____

_____

Health History

☐Allergies ☐Dizziness ☐PE tubes (ear ventilation)
☐ADD/ADHD ☐Epilepsy ☐Tonsils/Adenoids out
☐Autism Spectrum ☐Head Trauma ☐Taking medication
☐Ear infections/fluid ☐Hearing loss
☐Dyslexia ☐Neurologic problem ☐Other/s_____

Please provide information for checked items above:_____
_____
_____

Other Conditions

Do you have or have you had (to the best of your knowledge; even as a young child):

☐Coordination/muscle weakness ☐ Have/had hearing aid
☐Learning disability ☐Have/had speech-language therapy
☐Remedial reading help ☐Have/had occupational therapy
☐Speech-Language problem ☐Other (specify)_____

Please provide information about any problem checked_____
_____
_____

Other Evaluations

Have you seen other professionals regarding this or related problems (e.g., evaluation, therapy)?

☐No ☐yes If yes, please explain who was seen, when, why and what was found.

Who_____ Profession_____ When_____

Why_____ What was found_____

Who_____ Profession_____ When_____

Why_____ What was found_____

Who_____ Profession_____ When_____

Why_____ What was found_____

Please check if you believe/have been told that you have these traits or not (enter ? if unsure):

Trait	yes	no		Trait	yes	no
Anxiety, tension				Maintaining proper sequence/order		
Confused in noisy places				Mixes up sounds		
Does not express emotion				Needs quiet to study		
Does not finish tasks				Often says "huh" or "what" a lot		
Easily distracted				Poor understanding in noise		
Easily flustered or confused				Prefers one-to-one communication		
Easily frustrated				Prefers solitary activities		
Easily upset by new situations				Problems with the law		
Excessive talking				Restless, problems sitting still		
Fakes illness				Sensitivity to loud sounds		
Forgetful				Short attention span		
Had psychological counseling				Short-term memory problem		
Headaches				Speech unclear from another room		
Hyperactive				Tires easily		
Impulsive				Trouble following directions		
Inappropriate social behavior				Trouble telling where sounds are		
Involved with alcohol/drugs				Trouble understanding television		
Irritable				Trouble locating sounds		
Lacks motivation				Trouble understanding on the phone		
Lacks self-confidence				Uncooperative		

Educational History

Education Completed ☐Elementary ☐High School ☐College ☐Post Graduate ☐Other

Have you repeated a grade? ☐yes ☐no If yes, what grade? ___ Why?_____

Are you presently in a classroom situation? ☐yes ☐no

If yes, please explain any problems that you are experiencing _____

_____

_____

Other/comments:_____

_____

_____

Do you rely heavily on vision in class? ☐yes ☐no

Do any relatives have problems in school? ☐yes ☐no

If yes, who and problem:_____

THANK YOU FOR YOUR ASSISTANCE BY COMPLETING THIS QUESTIONNAIRE

BUFFALO MODEL QUESTIONNAIRE-REVISED

Name _____ **Date** _____

Age _____ **Grade** _____ **Form completed by** _____

Please circle 'Y' if your child is currently receiving or has received any of the services and indicate the number of years received:

Y Auditory training? ___ yrs	Y Speech therapy? ___ yrs	Y Phonological awareness training? ___ yrs
Y Special phonics training? ___ yrs	Y Reading therapy/tutoring? ___ yrs	Y Sensory-integration training? ___ yrs

1) Please circle 'Y' if this *may be a problem* or 'N' if *not a problem*
2) If it does not apply, circle 'NA' (e.g., if a kindergartner has no foreign language training; circle 'NA' for #8)

DEC				
1)	Y	N	NA	Speech (saying sounds)
2)	Y	N	NA	Understand language
3)	Y	N	NA	Understand verbal directions
4)	Y	N	NA	Oral Reading Accuracy
5)	Y	N	NA	Phonics
6)	Y	N	NA	Spelling
7)	Y	N	NA	Responds slowly/delayed
8)	Y	N	NA	Foreign language learning
9)	Y	N	NA	Speaks slowly
Noi				
10)	Y	N	NA	Hypersensitive to sounds
11)	Y	N	NA	Distracted by sounds
12)	Y	N	NA	Understand speech in noise
13)	Y	N	NA	Noisy child/makes noises
Mem				
14)	Y	N	NA	Responds quickly
15)	Y	N	NA	Frequently interrupts others
16)	Y	N	NA	Reading Comprehension
17)	Y	N	NA	Speaks quickly
18)	Y	N	NA	Forgets things told
19)	Y	N	NA	Forgets oral directions
Var				
20)	Y	N	NA	Attention
21)	Y	N	NA	Using language
22)	Y	N	NA	ADHD/ADD
23)	Y	N	NA	Anxiety (e.g. new situations)
INT				
24)	Y	N	NA	Very poor handwriting
25)	Y	N	NA	Easily associates sounds & letters
26)	Y	N	NA	Severe reading/spelling
27)	Y	N	NA	Severe visual perception
28)	Y	N	NA	Sometimes very long delays
29)	Y	N	NA	Dyslexia
ORG				
30)	Y	N	NA	Belongings are disorganized
31)	Y	N	NA	Sequence verbal items correctly
32)	Y	N	NA	Messy/tends to lose things
APD				
33)	Y	N	NA	Ear infections/ ear fluid as child
34)	Y	N	NA	Processing what is heard
35)	Y	N	NA	Learning problems (LD)
36)	Y	N	NA	Following verbal directions
37)	Y	N	NA	Intellectually challenged
38)	Y	N	NA	Head injury
39)	Y	N	NA	Autism or related problem
Gen				
40)	Y	N	NA	Hypersensitive to touch
41)	Y	N	NA	Eye contact with speaker
42)	Y	N	NA	Long-term memory
43)	Y	N	NA	Psychological
44)	Y	N	NA	Behavior
45)	Y	N	NA	Coordination
46)	Y	N	NA	Allergies
47)	Y	N	NA	Math
48)	Y	N	NA	Hearing

Comments, explanations, questions: _____

_____

For Office Use Only

DEC	(Noi)	(Mem)	(Var)	TFM	INT	ORG	APD	ΣCAP	(Gen)
/9	(/4)	(/6)	(/4)	/14	/6	/3	/7	/39	(/9)