330 Borthwick Avenue, Suite 209
Portsmouth, NH 03801
(603) 436-8668
Fax: (603) 436-4499

62 Portsmouth Avenue, Suite 10
Windy Knoll Plaza
Stratham, NH 03885
(603) 778-7620
Fax: (603) 778-0009

Child Patient Information Sheet

LAST NAME: _____ FIRST NAME/ MI: _____
ADDRESS: _____ CITY/ST: _____ ZIP: _____
PHONE #: (_____)_____ BIRTHDATE: _____GENDER: M☐F☐
REFERRED BY: _____
PEDIATRICIAN/PRIMARY CARE PHYSICIAN NAME AND ADDRESS: _____
_____

PARENT/GUARDIAN INFORMATION

PARENT: OTHER:
LAST NAME: _____ FIRST NAME/ MI: _____
STREET 1: _____ STREET 2: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE_____CELL PHONE_____WORK PHONE_____
EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Name:_____	Insurance Name:_____
Claims Address:_____	Claims Address:_____
_____	_____
Policyholder Name:_____	Policyholder Name:_____
Relationship to Policyholder: Self___ Child___	Relationship to Policyholder Self___ Child_____
Policyholder Date of Birth_____	Policyholder Date of Birth_____
Policy ID#_____	Policy ID#:_____
Policy Group#_____	Policy Group#_____

I understand that I am financially responsible for the charges for the services provided that may not be covered by my insurance company and that if not covered by my policy contract, I will be responsible for the entire bill.

I also allow Professional Audiology Center to release my records in the event my insurance company requests them for consideration of payment.

Signature of Responsible Party: _____ Date: _____

How did you learn about our office? Please indicate all that apply.

☐ Early Intervention ☐ School ☐ Therapist/Specialist ☐ Friend
☐ Physician ☐ Yellow Pages ☐ Internet ☐ Newspaper/Magazine ☐ Mail Advertising

Child's Pediatrician Name and Address: _____
_____
Father's Name _____ Work # _____
Mother's Name _____ Work # _____
Brothers and Sisters? (names and ages) _____
Parent's chief concerns:_____
When did you first notice this problem?_____
What do you think caused this
problem?_____
_____

HEALTH HISTORY:

Yes No

☐ ☐ 1. Were there any problems during the pregnancy, the delivery, or following the birth of this child? If yes, pleaseexplain._____
_____
_____

☐ ☐ 2. During pregnancy, was mother exposed to any viral or bacterial infections? _____

3. Child's gestation age at birth_____weeks; Birthweight_____ Apgar Score (s)_____

☐ ☐ 4. Was the child treated for high bilirubin levels(jaundice)?

☐ ☐ 5. Was oxygen administered to the child following delivery? If yes, explain why and for how long.
_____

☐ ☐ 6. Has this child had any serious illnesses, accidents, or hospitalizations? If yes, please explain.
_____
_____

☐ ☐ 7. Has this child had repeated ear infections? If yes, please describe when they started, how many, and the most recent one:_____
_____
_____

☐ ☐ 8. Is your child presently on any medications? If yes, please indicate which medication and what it is being taken for _____
_____

☐ ☐ 9. Has your child ever been rendered unconscious from a fall or blow to the head? If yes, please explain the date, treatment, and physician._____
_____

☐ ☐ 10. Are there any relatives with known hearing loss? If yes, write the relationship to child, and age of onset.
_____
_____

Yes No

☐ ☐ 11.Are there any relatives with birth defects or abnormalities?_____
_____

12. This child's general health is: Excellent____ Good____ Fair____ Poor____
Please explain any health concerns._____
_____
_____

DEVELOPMENTAL HISTORY:

Please describe any concerns that you or your pediatrician has regarding any unusual behavior or slow development, including any speech issues._____
_____
_____

While keeping your child's age in mind, please rate the following:

Motor Coordination and balance:	Excellent	Good	Fair	Poor
Eye/hand coordination:	Excellent	Good	Fair	Poor
General behavior at home:	Excellent	Good	Fair	Poor
Ability to play with other children:	Excellent	Good	Fair	Poor
Ability to keep attention on activity:	Excellent	Good	Fair	Poor
Plays appropriately with toys:	Excellent	Good	Fair	Poor
Ability to solve problems:	Excellent	Good	Fair	Poor
Ability to follow directions:	Excellent	Good	Fair	Poor
Ability to speak clearly:	Excellent	Good	Fair	Poor

EDUCATIONAL HISTORY:
School and Address:_____

School Placement:_____
(Grade) (Teacher)

Progress in School? Excellent Good Fair Poor

Any grades repeated?_____

Previous evaluations and/or training: (when, where, by whom, and results)_____

_____

NOTE TO PARENTS/CARE GIVERS FROM THE AUDIOLOGISTS

If your child is under six year of age, we may ask you to assist during the audiological testing.

Other children in your care cannot accompany you into the test booth as it may be a distraction for the child we are testing. Therefore, we ask that you make appropriate arrangements for child care.

Thank you!