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INTAKE FORM FOR CHILDREN AND ADOLESCENTS

In order for me to best help you and your child, please fill out the following information. All information is strictly confidential and cannot be legally released without your written permission. Please use the back of this page for additional information, if necessary.

CHILD'S NAME _____ BIRTHDATE _____
Last First Middle

ADDRESS_____
Street City State Zip

SCHOOL _____GRADE _____

Type of Program? Oral_____ Sign Language _____Total Commun _____

FAMILY INFORMATION

MOTHER_____ _____Phone _____ H W
Name Occupation

FATHER_____ _____ Phone _____ H W
Name Occupation

Marital Status: Single _____Married _____ Separated _____Divorced _____

If divorced, give date and current custody arrangement? _____

Brothers/sisters and others in home?

_____

_____

REFERRED BY: Self ____ Doctor _____ Insurance Co. ____ Other _____

INSURANCE COMPANY _____ POLICY/GROUP# _____

MAJOR REASON FOR SEEKING HELP AT THIS TIME _____

_____

_____

PLEASE LIST PREVIOUS THERAPY, COUNSELING OR HOSPITALIZATIONS

YEAR THERAPIST LOCATION HOW LONG? RESULTS?

_____

_____

MEDICAL HISTORY

Was pregnancy normal? Yes ____ NO_____ If not, what unusual circumstances were there ? _____

Is child adopted ? Yes____ NO _____ , If so, at what age was she adopted? _____

Date of last medical examination _____ last audiological examination _____

Any medications?_____ For what?_____

List serious illnesses, injuries, surgeries or hospitalizations and dates:

_____

_____

HISTORY OF HEARING IMPAIRMENT

When was your child's hearing impairment first diagnosed?_____

Who diagnosed it? _____

Degree of hearing impairment i.e. db loss? R ____ L ____

What is the cause of the hearing loss (if known)? Wears hearing aids? R ____L ___

Name and phone # of audiologist/ENT Dr. _____

Child's primary mode of communication in home _____ at school

_____. Age started with oral or sign language training _____

How does your child let others know what her/his needs are? _____

SOCIAL AND EMOTIONAL INFORMATION
How does your child get along with:

Mother_____ Grandparents _____

Father _____ Siblings _____

Peers?_____ Other significant person (s) _____

What hobbies, interests or special skills does your child have? _____

_____

Does your child complain of or show any of the following behaviors?

____ Headaches
____ Loneliness
____ Worried
____ Depressed
____ Trouble concentrating
____ Trouble sleeping
____ Nightmares
____ Stomachache
____ Difficulty in school
____ Trouble with teacher
____ Resistance wearing hearing aids
____ Embarassment about hearing loss
____ Easily frustrated
____ Temper tantrums
____ Lying, distorting truth
____ Hostile or aggressive

Any other information that you think would be helpful for me to know? _____

_____

_____

Thank you for taking the time to answer this form.