Project TALK/Pediatric Hearing Specialists

2210 Encinitas Blvd. Ste O ~ Encinitas, CA 92024
(760) 634-1553

PATIENT INFORMATION FORM

PATIENT'S NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

FATHER'S NAME:_____ DATE OF BIRTH:_____

ADDRESS (IF DIFFERENT):_____

HOME TELEPHONE:_____ WORK TELEPHONE:_____

CELL PHONE:_____ OCCUPATION_____

EMPLOYER_____EMPLOYER'S ADDRESS:_____

MOTHER'S NAME:_____ DATE OF BIRTH:_____

ADDRESS (IF DIFFERENT):_____

HOME TELEPHONE:_____ WORK TELEPHONE:_____

CELL PHONE:_____ OCCUPATION_____

EMPLOYER_____EMPLOYER'S ADDRESS:_____

SIBLINGS/AGES:_____

PLEASE INDICATE (x) PARTY TO BE BILLED FOR SERVICES RENDERED:

_____**Self Pay** _____**Scholarship** _____**School district (please note name of district)**

_____**Insurance (please complete ALL information below or we will not bill insurance):**

NAME OF FAMILY MEMBER WHO CARRIES THE INSURANCE:_____

ID #_____ GROUP NUMBER:_____

INSURANCE COMPANY NAME:_____

BILLING ADDRESS:_____

INSURANCE COMPANY TELEPHONE:_____

I authorize the release of any medical or other information necessary to determine eligibility and to process claims. I authorize payment of medical benefits to Project TALK/Pediatric Hearing Specialists. I accept that I am ultimately financially responsible for all services received.

_____ _____

Signature of Patient or Parent/Guardian (if under 18) Date

CASE HISTORY

A. PRE-NATAL HISTORY

1. What was the condition of the mother's health during pregnancy?_____
2. What drugs were taken during pregnancy?_____
3. Did the mother have any of the following during pregnancy: ___fever; ___high blood pressure; ___ diabetes; ___ toxemia; ___Rubella (German measles); ___CMV; ___Rh incompatibility?

B. BIRTH HISTORY

1. What was the length of pregnancy?_____
2. What was the duration of labor?_____ What type of delivery?_____
3. What was the birth weight?_____ birth length?_____
4. Did your baby have any of the following? ___jaundice; ___anoxia (lack of oxygen); ___birth injury; ___blood transfusion.
5. Were there any breathing, feeding, sucking or swallowing difficulties?_____
6. How long was the baby's hospital stay?_____ If the hospital stay was longer than normal, what treatments did your baby receive?_____
_____
7. Did your baby receive newborn hearing screening prior to discharge from the hospital?_____
If so, what test was done and what were the results?_____

C. HEALTH HISTORY

1. Please indicate the date your child had any of the following illnesses: ___Chicken pox; ___Scarlet Fever; ___Whooping Cough; ___Cerebral Palsy; ___Mumps; ___Rubella; ___Rubeola; ___Meningitis; ___Asthma; ___Head Injury; ___Convulsions; ___Dizziness; ___High Fever.
2. Has you child been hospitalized for any reason? (Explain)_____
_____
3. Does your child have eye problems and/or wear glasses?_____
4.Are there any other health problems other than hearing loss? (Explain)
_____
_____

D. HEARING HISTORY

1. When was the hearing loss suspected?_____
2. Who suspected it and why?_____
3. What action was taken? (Include names, dates, tests)_____
_____
_____
4. What do you think caused the hearing loss?_____
5. Is there any hearing loss in your family?_____
6. Did you and/or your child receive genetic counseling or testing?_____ If so, what were the results?_____
7. When was the child fitted with hearing aids?_____ What type of hearing aids?_____
8. What was your child's response to hearing aids?_____
9. Does your child have a cochlear implant?_____ When was your child implanted?_____
Where was your child implanted?_____ Surgeon's name?_____

Audiologist's name?_____ Type of implant?_____
Which ear was implanted?_____ Does your child wear a hearing aid with the implant?_____
10. What was your child's response to the cochlear implant?_____
11 .Does your child have a history of ear infections?_____
12. Does the hearing seem to fluctuate?_____
13. How many hours per day does your child wear his hearing aids and/or implant?_____
14. What are your current concerns with your child's hearing aids and/or implant?_____
_____
15. Does anyone in your family have a speech, language, and/or learning disability?_____
_____

E. CHILD'S DEVELOPMENT

1. When did your child: sit_____; crawl_____; walk_____?
2. Is your child toilet trained?_____
3. Does your child favor one hand?_____ Which one?_____
4. What is your child's best time of day?_____
5. How are his sleeping habits?_____
6. Is he restless or overactive?_____
7. What behavior problems do you encounter?_____
_____
8. What is your method of discipline?_____
_____
9. How would you describe your child's temperament?_____
10. To what sounds does your child respond?_____
11. What sounds does he babble?_____
12. What words does he understand?_____
13. What words does he say?_____
14. Does he use sentences?_____ Give an example:_____
_____
15. How does he communicate his needs?_____
16. How do you communicate with him?_____
17. What is your biggest frustration in communicating with your child?_____
_____
18. In what areas does your child appear advanced?_____
19. In what areas does your child appear delayed?_____
20. Is your child receiving services to assist with other areas of development?_____ If so, what? __
_____
21. Do you have any specific concerns about your child's development?_____
_____

F. GENERAL INFORMATION

1. In what educational programs is your child involved?_____
_____

2. How many hours a day does he watch TV?_____ What shows?_____
3. How many hours does he sleep at naps?_____ At night?_____ How often does he wake during the night?_____ What is his typical bedtime?_____ What time does he typically wake?_____
4. How are his eating habilts?_____
5. Is your child currently taking any medication?____ What medication and why?_____
_____
6. What are your child's current play interests?_____
7. How does your child respond to his peers?_____
8. What types of play does your child do with his peers?_____
How does he communicate with his peers?_____
9. What is your primary concern for your child?_____
_____
10. Is there any other information which would be important for helping your child?_____
_____
11. How did you hear of my services?_____

All of the above answers on the Patient Information Form and Case History Form are true and complete according to the best of my knowledge and belief.

_____ _____
Signature of Parent/Guardian Date