PLEASE TELL US LITTLE ABOUT YOUR CHILD………

NAME: ____ DATE OF BIRTH: ___/_____/_________

GUARDIAN NAME: ____MOTHER [ ] FATHER [ ]

MOBILE PHONE: ____

OCCUPATION: ____ ANY OTHER NUMBER: _______________

REFFERING DOCTOR: _____________________________ CONTACT________________________________

1. Do you have any concerns about your child's hearing? [YES] [NO]

   If yes, please explain: ____
2. Does your child have any speech issues/speech delay? [YES] [NO]

   If yes, has your child ever had speech therapy? [YES] [NO]

   If yes, where were services received? ____
3. Did your child get his/her newborn hearing screening? [YES] [NO]
4. Has any member of your family, or your child's teacher, ever expressed concern about your child's hearing ability? [YES] [NO]
5. Does your child wear hearing aids? [YES] [NO]

   If yes, when was your child first fit? ____
   Who did your child see for his/her hearing aids? _________________________________
6. Does your child have preferential classroom seating or special classroom accommodations? [YES] [NO]
7. Has your child had a formal hearing test by an Audiologist? [YES] [NO]
8. Was the pregnancy of this child free of complications? [YES] [NO]

   If no, please explain: ____
9. Has your child suffered any serious illnesses/Had any surgeries? [YES] [NO]

   If yes, please explain: ____