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AUDITORY PROCESSING INTAKE

Patient Information:

Parent Name(s): _____ Date: _____

Patient Name: _____ D.O.B. _____

Address: _____

City: _____ Postal Code: _____

Phone Number: _____

School: _____ Grade: _____

Public _____ Separate _____ Private _____ French Immersion _____ Other Lang. Immersion _____

Language(s) spoken at home: _____ Handedness: _____

Classroom setting: _____ (e.g. split grade, open concept)

Siblings: _____

Mother's occupation: _____

Father's occupation: _____

Reason for this referral: _____

Individual who referred you: _____

I hereby give my consent for the assessment of my child's hearing and central auditory processing

Name of Parent or Legal Guardian (PRINT)

Signature

Medical History:

History of perinatal /and/or pre-natal complications: Y/N _____

Describe: _____

Premature: Y/N _____ Gestational Age: _____ Multiple Birth: _____

History of allergies: Y/N _____ Upper airway disease: _____ Asthma: _____

Does your child have a permanent hearing loss? _____

When was it diagnosed? _____

Does your child have a history of middle ear disease (otitis media)? _____

Age of first infection: _____ Number of infections: _____

Tubes? _____ Number of times: _____

Other surgery: _____

Developmental History:

Has your child had:

- A psychological assessment: _____ With whom: _____

When: _____

- A speech-language assessment: _____ With whom: _____

When: _____

- An educational assessment: _____ With whom: _____

When: _____

- An assessment for ADHD (attention deficit disorder/hyperactivity) _____

With whom: _____ When: _____

Treatment prescribed (Y/N): _____ Commenced? _____

Speech and Language Development:

Is your child presently receiving speech therapy? _____

Age at which your child began to speak: _____

Would you say her/his language was similar to her/his peers, earlier, later? _____

Does your child have any articulation errors? (mispronounced sounds) _____

Remediation:

Is your child receiving tutoring? _____ Behavioural intervention: _____

Counselling? _____

Has any intervention been used at school? _____

Describe: _____

Has your child been diagnosed with a learning disability? _____

Has your child been through the formal designation at school (IPRC)? _____

Has any other family member been diagnosed with a learning disability? _____

Who? _____

What are your concerns about your child? _____