BLUEWATER HEARING

Name:_____Date of Birth:_____Age: _____

Address:_____
Street City/Town Postal Code

Phone:_____

Child Lives with: Both parents: ___ Mother: ___ Father: ___ Other: ___

Parent Name(s):_____

Referred from:_____

Family Doctor:_____

School attending:_____Grade:_____

Hearing History

Do you have any concerns about your child's hearing? Yes ___ No ___
If yes, please list by whom, when and results: _____

_____

Does anyone in your family have hearing loss
(immediate and extended family) that began before the age of 30? Yes ___ No ___

Does your child consistently respond to your voice? Yes ___ No ___

Does your child respond to loud noises? Yes ___ No ___

When sound is present or someone is speaking, does
your child search to find where the sound is coming from? Yes ___ No ___

Does your child respond to sounds from other rooms? Yes ___ No ___

Has your child's hearing ever been tested? Yes ___ No ___
If yes, please list by whom, when and results: _____

_____

Does your child wear hearing aid(s)? Yes ___ No ___
If yes, when was your child first fit? _____

Does your child use an auditory trainer? Yes ___ No ___

Does your child receive preferential classroom seating? Yes ___ No ___

Continue ▶

BLUEWATER HEARING

Pregnancy and Birth

Was the pregnancy abnormal in any way? Yes ___ No ___

Was the delivery abnormal in any way? Yes ___ No ___

Was the delivery premature? Yes ___ No ___

Did the mother have any illness during the pregnancy? Yes ___ No ___

Did the mother take any medication during the pregnancy? Yes ___ No ___

After birth, did your child have:

Breathing difficulties? Yes ___ No ___

Require an incubator? Yes ___ No ___

Any head, neck or ear abnormalities? Yes ___ No ___

Feeding problems? Yes ___ No ___

Surgery? Yes ___ No ___

If yes to any of the above, briefly explain:_____

_____

Medical History

Do you have any medical concerns about your child? Yes ___ No ___

If yes, briefly explain: _____

_____

Please check if your child has had any of the following:

Ear infections ___ Meningitis ___ Seizures ___ Ear surgery ___ Measles ___

Kidney problems ___ Hospitalization ___ Mumps ___ Vision problems ___

Head trauma/injury ___ Chicken pox ___ Allergies ___ Asthma ___

Noise exposure (e.g. farm equipment, loud music) ___

If yes to any of the above, briefly explain:_____

_____

Other significant medical concerns: _____

_____

Please list any prescription or over-the-counter medications your child is taking and for what reason(s):

_____

_____

Continue ▶

Sarnia: 714 London Road
Sarnia Ontario N7T 4X6

Petrolia: 4130 Glenview Road
Petrolia, Ontario N0N 1R0

Corunna: 348 Lyndoch Street
Corunna, Ontario N0N 1G0

BLUEWATER HEARING

Physical Development History

Do you have any concerns about your child's physical development? Yes ___ No ___

Speech and Language History

Do you have any concerns about your child's speech and language? Yes ___ No ___
If yes, briefly explain: _____

_____

About what age did your child:

Follow simple directions_____ Say his/her first word_____ Put two words together_____

Did your child continue adding words after the first word? Yes ___ No ___

If your child is 2 years old or younger, how many words does he/she use? _____

Does your child often use gestures when communicating? Yes ___ No ___

Is your child's speech understood by: Parents ___ Siblings ___ Other adults ___

Has your child's speech ever been evaluated? Yes ___ No ___
If yes, please list by whom, when and what were the results: _____

_____

Is your child currently receiving speech therapy? Yes ___ No ___

Additional History

Do you have any other concerns about your child? Yes ___ No ___
If yes, briefly explain: _____

_____

Does your child:

Play/interact well with other children? Yes___ No___

Have attention/concentration difficulties? Yes___ No___

Receive any special education services? Yes___ No___

Do you feel that your child is having any difficulty in school? Yes ___ No ___
If yes, briefly explain: _____

_____

_____ _____ _____

Signature of person completing this form **Relationship to child** **Date**

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BLUEWATER HEARING

CONSENT TO ASSESSMENT AND RELEASE OF INFORMATION

Client Name:_____Date of Birth:_____

I, _____
(CLIENT/PARENT/LEGAL GUARDIAN-PLEASE PRINT)

☐ Consent to an assessment by Blue Water Family Hearing of the above client.

☐ Consent to sharing information about this client with those listed below. (For example; family physician, specialists, school, community or other agencies) Please give the name of the school if your wish the school/teacher to receive information. Please include addresses of out-of-town physicians, if possible.

☐ I understand that the report of the initial assessment will be sent to the referring physician and that I will be placed on a recall list if needed.

Information may be transmitted by fax or electronically.

1._____
2._____
3._____
4._____
5._____
6._____

☐ I would like to receive information by e-mail (please initial) _____
(I understand that e-mail is NOT confidential)

The client/parent/legal guardian may change or revoke details of this consent at any time.

_____	_____	_____
Signature of person completing this form	**Relationship to child**	**Date**

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