COLE AUDIOLOGY LAB
Human Services Bldg. Room 205
P.O. Box 13019, SFA Station
Nacogdoches, TX 75962- 3019
F: 936.468.7096
P: 936.468.7109

Child Hearing History

Today's Date:_____

Patient Information:

Patient Name: _____ Date of Birth: _____

Age_____ Sex ____ Race _____Parent's Name_____

Primary Phone _____ Secondary Phone_____

Address_____
Street City State Zip Code

Child's Physician: _____

Referred to Cole Audiology Lab by: _____

Reason for Referral: _____

Primary Concern: Please circle **Yes** or **No** and describe below.

Do you feel this child has a hearing loss?_____ Yes No
Are you concerned about this child's speech or language development? Yes No
Please describe Concern: _____
_____

Prenatal and Birth History:

Length of Pregnancy:_____ Birth Weight: _____

Complications during delivery: _____

Newborn Hearing Screening Results: _____

After birth, did this child have: Circle **Yes** or **No**

Breathing Difficulties?	Yes No
Admission to the Intensive Care Unit?	Yes No
Head, neck or ear abnormalities?	Yes No
Skin tags or pits near the ears?	Yes No
Jaundice?	Yes No
Head trauma/defect?	Yes No
Surgery?	Yes No
Diagnosis of a neurologic condition?	Yes No
Diagnosis or suspicion of a syndrome?	Yes No
Vision problems?	Yes No
Kidney problems?	Yes No

Family History:

Family history of hearing loss before age 40? Yes No
Please describe: _____
_____

Hearing and Middle ear History:

Previous hearing test? _____ Yes No
Allergies? _____Yes No
Noise exposure? _____ Yes No
Noises or ringing in the ears? _____ Yes No
Balance or coordination difficulties? _____ Yes No

Please describe:
_____
_____

Number of ear infections: _____
P.E. Tubes placed? _____ if yes, by whom and when were they placed?
_____
_____

History of ear pain? _____
Does child complain of loud sounds? _____
Does child startle to loud noises? _____
Does child search to find the source of sound? _____

Stephen F. Austin State University
Cole Audiology Lab

Information Regarding Protected Health Information

I have read the Notice of Health Information Practices provided by the Stephen F. Austin State University Cole Audiology Lab. I understand how the Audiology Lab will utilize my protected health information (PHI) and my rights regarding my protected health information.

Payment Responsibility

We request that office visits be paid at the time service is rendered. Any unpaid balance is due within 30 days regardless of insurance claim status, unless otherwise specified.

I understand that I am responsible for all charges for the services rendered to me or my dependents regardless of insurance.

_____ _____

Client or Parent/Guardian *Date*

AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED HEALTH INFORMATION

I have read the Notice of Health Information Practices provided by the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. I understand how the clinic will utilize my or my child's protected health information (PHI) and my rights regarding my protected health information.

_____ _____
Client or Legal Guardian *Date*

I undersigned, authorized the Stephen F. Austin State University Stanley Center for Speech and Language Disorders to acquire and/or release professional information to:

_____
Agency/Individual Name

_____
Address

_____
Phone Number

For the purpose of:
_____
_____

I authorize release of the following:
_____
_____

I understand that I may revoke this authorization by submitting a written request to the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. Such a revocation does not apply to releases prior to the date of the request.

_____ _____
Client or Legal Guardian *Date*