StyleTone Hearing Care, LLC
Doris A. Rapisardi, MAS-CCC-A, Founder/Director
NJ AUD Lic. # 149 NJ HA Lic. #614
www.styletonehearing.com

860 Route 10 West
Randolph, New Jersey 07869
(Tel) 973-927-3433 (Fax) 973-927-3473

StyleTone Hearing Care Pediatric Audiology Intake

Personal Information

Date of Intake: _____

Child's Name: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female Handedness: ☐ Right ☐ Left
Child's School _____ Grade _____

Parent/Guardian: _____ Relationship: _____
Date of Birth: _____ Email: _____
Occupation: _____ Employer _____

Parent/Guardian: _____ Relationship: _____
Date of Birth: _____ Email: _____
Occupation: _____ Employer: _____

Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
: _____
Ins. Carrier: _____
Ins. Holder: _____
Policy # _____ Group #

Pediatrician's Information

Pediatrician: _____ Send report? ☐ Yes ☐ No
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____
FAX: _____

REFERRED BY:

Referral: _____ Send report? ☐ Yes ☐ No
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

Notice of Parental/Guarantor Responsibilities

- Payment is expected at the time of the service unless other arrangements have been made in advance.
- It is your responsibility to understand your benefits and all obligations set forth by your insurance company.
- We require 24-hour notice to cancel or reschedule appointments; failure to do so will incur a $50 cancellation fee.

By signing below, I acknowledge that have read and understood the above information.

_____ _____
Print Patient's Name Signature of Parent/Guardian

STYLETONE HEARING CARE, LLC: Please initial and date that you have read and understood our HIPAA and privacy practices (available in office at time of visit): initials _____ **date:** _____

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Birth History

Prematurity: ☐ Yes ☐ No Gestational Age at Birth: weeks

Jaundice: ☐ Yes ☐ No

Complications during pregnancy/delivery:

Medical attention following birth:

Blood transfusion	☐ Yes ☐ No
Medications	☐ Yes ☐ No
Cleft Palate	☐ Yes ☐ No
Craniofacial Anomalies	☐ Yes ☐ No
Lack of Oxygen	☐ Yes ☐ No
	Explain if yes

Did any family member smoke cigarettes in the household during pregnancy? ☐ Yes ☐ No
Explain:

Developmental History

Did your child have delayed speech/language development? ☐ Yes ☐ No Explain:

Did your child have delayed motor development? ☐ Yes ☐ No Explain:

Did your child have Sensory issues? ☐ Yes ☐ No Explain:

Did your child receive Early Intervention Services? ☐ Yes ☐ No If So: ☐ Speech Therapy ☐ OT ☐ PT ☐ Sensory Integration ☐ Play Group

Medical History

Does your child present with any of the following medical conditions?
- ☐ Head trauma/injury
- ☐ Seizure disorders
- ☐ Visual problems
- ☐ Syndrome _____
- ☐ Other _____

Does your child have any of the following diagnoses?
- ☐ Seizure Disorder
- ☐ ADHD/ADD/Attention difficulties
- ☐ Anxiety and/or Depression
- ☐ Autism/PDD/Asperger's Disorder
- ☐ Learning Disability
- ☐ Language Disorder/Articulation Disorder
- ☐ Hearing Loss

Does your child currently take any medications? ☐ Yes ☐ No
List:

Does your child currently receive any outpatient therapy services? ☐ Speech/Language ☐ OT ☐ PT ☐ SI ☐ Other:

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Family History

Did/Does any family member have any of the following diagnoses:		Mother	Father	Sibling
	Seizure Disorder	☐	☐	☐
	ADHD/ADD	☐	☐	☐
	Anxiety/Depression	☐	☐	☐
	Autism/PDD/Asperger's	☐	☐	☐
	Learning Disability	☐	☐	☐
	Language Disorder	☐	☐	☐
	Articulation Disorder	☐	☐	☐
	Hearing Loss	☐	☐	☐
	Auditory Processing	☐	☐	☐
	Dyslexia	☐	☐	☐
	Genetic Syndromes	☐	☐	☐
Is your child adopted?	☐ Yes ☐ No			
Please list any additional languages spoken in the home:				
Was your child's first language English?				
Please list any other important family history here:				

Hearing History

Did your child pass the newborn hearing screening?	☐ Yes ☐ No Follow-up:	
When your child was's last hearing screening or evaluation?	Date:	Results:
Does your child have a history of ear infections?	☐ Yes ☐ No	Treated By: ☐ Antibiotics ☐ Tubes (# of sets)
Has your child ever had an auditory processing evaluation?	☐ Yes ☐ No Results:	

Please explain reason for referral and concerns you have about your child's hearing

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****The following section is to be completed ONLY if your child will be receiving an Auditory Processing Evaluation****

Educational History

Current School:		District:
Current Grade:		Repeated Grade? ☐ Yes ☐ No
Educational Setting:	☐ Regular Ed. ☐ Inclusion Ed.	☐ Other _____
Education Plan:	☐ 504 Accommodations	☐ Individualized Ed Plan (IEP)
	☐ Academic Instruct. Svs. (AIS)	
Current Therapies: ☐ None	☐ Speech/Language (/wk)	☐ Occupational Therapy (/wk)
	☐ Physical Therapy (/wk)	☐ Reading Instruction (/wk)
	☐ Resource Room (/wk)	☐ 1:1 Aide in Classroom (☐part-time or ☐full-time)
My child has difficulties with:	☐ Reading	☐ Math
	☐ Spelling	☐ Organization
	☐ Phonics	☐ Grammar
	☐ Foreign Language	☐ Sciences
	☐ Other	

Visual Skills

Last visual examination?	MD:		
	Does your child use glasses?	☐ Yes ☐ No	
	☐Far-Sighted	How Long?	
	☐Near-Sighted		
	☐Astigmatism		
Does your child . . .	Lose place when reading?	☐ Yes	☐ No
	Skip/re-read lines?	☐ Yes	☐ No
	Skip/add-in words?	☐ Yes	☐ No
	Notice words moving/running together?	☐ Yes	☐ No
	Confuse words with similar endings/beginnings?	☐ Yes	☐ No
	Complain of intermittent blur at near?	☐ Yes	☐ No
	Does your child present with the following symptoms?	☐ Eyestrain	☐ Rubs eyes
		☐ Headaches	☐ Double Vision
	☐ None	☐ Eyes tear	

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Previous Testing: Please forward all recent educational reports for review prior to your child's appointment

Discipline	Tests Administered	Results:	
Psychology	☐ WISC-IV ☐ WAIS ☐ Other:	Verbal: Processing Speed: Performance: Working Memory: Full Scale:	Neuropsychological Testing (if applicable). Please list:
Speech	Tests:	Receptive: Expressive: Integrative: Pragmatic: Articulation:	
OT	Tests:	Fine Motor: Visual Motor: Visual Perceptual: Sensory:	
Education	Tests:	Written Expression: Reading: Spelling: Math: Other:	

Please feel free to inform us of any other pertinent information regarding your child in the space below: