

PARENT QUESTIONNAIRE

Ear & Hearing Center
 Cincinnati Children's Hospital Medical Center
 3333 Burnet Avenue
 Cincinnati, Ohio 45229-3039
 (513) 636-4236

Date Completed: _____

Child's name _____ Sex: M F Birth date _____ Age _____

Mother/Caretaker	Father/Caretaker
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____	Phone: _____

1. FAMILY INFORMATION

 Are biological parents married? **Yes No**

If biological parents are not married at this time, who has custody? _____

****Must include a copy of appropriate custody papers.**

 Who is the child's primary **care giver**? _____

Who takes care of your child while you are at work? _____

Mother's Age _____

Occupation _____ How many hours you work per week: _____

Place of Employment _____ Work phone _____

Last grade completed _____

Father's Age _____

Occupation _____ How many hours you work per week: _____

Place of Employment _____ Work phone _____

Last grade completed _____

Step-Mother's Name _____ Age _____

Occupation _____ How many hours you work per week: _____

Place of Employment _____ Work phone _____

Last grade completed _____

Step-Father's Name _____ Age _____
Occupation _____ How many hours you work per week: _____
Place of Employment _____ Work phone _____
Last grade completed _____

2. HISTORY OF HEARING LOSS:

When did you find out that your child had a hearing loss?

How old was your child?

Who told you that your child had a hearing loss?

Do you know what caused your child's hearing loss?

When did you first suspect that your child had a hearing loss?

Where has your child's hearing been tested?

Since it was first identified, has your child's **hearing loss**: (circle one)

remained the same

gotten worse

gotten better

How old was your child when he/she started wearing hearing aids? _____

Do the hearing aids seem to help your child?

Yes No Unsure

Have any other family members had trouble with their hearing or had ear surgery? If so, please explain _____

3. MEDICAL HISTORY:

Did your child have any problems at birth or need to be hospitalized following birth?

Please explain. _____

Has your child had any significant illnesses? If so, please describe, including age of onset. _____

DISEASES AFFECTING THE MIDDLE EARS

Has your child experienced any of the following:

Sinusitis <input type="checkbox"/>	Frequent Colds <input type="checkbox"/>	Nasal Allergy <input type="checkbox"/>	Ear infections <input type="checkbox"/>
Ear Tubes <input type="checkbox"/>	When:		Who put in the tubes?

Please list the medication(s) your child is now taking:

Has your child ever been hospitalized? **Yes No** At what age? _____
 Why was your child hospitalized?

Has your child ever had surgery? **Yes No** At what age? _____
 What surgeries were completed? _____

Has your child ever had any serious accidents requiring medical care? **Yes No**
 Please explain

Do you think your child has trouble with balance or coordination? **Yes No**

Does your child complain of head noise or ringing in his/her ears? **Yes No**

Does your child receive:	No	Yes	Where, how often, therapist name
Speech therapy			
Aural rehabilitation			
Physical therapy			
Occupational therapy			
Other			

Please list any other medical questions or concerns that you have. _____

Is your child enrolled in:	No	Yes	Name of contact
Early Intervention			
Help Me Grow			
1st Steps (in KY)			
Every Child Succeeds			
Health Dept.			
Head Start			
RIHP (in OH)			
Auditory Options (in OH)			
MRDD			
Have you ever had or are you currently involvement with:			
School Advocate			
JFS/Child Protective Services			
Other (Please give program name and name of worker)			

5. COMMUNICATION HISTORY:

How does your child communicate with you? _____

When did your child start communicating this way? _____

How well does your child communicate with the rest of your family? _____

6. SCHOOL HISTORY:

Name of child's school/daycare: _____ Grade: _____

School address: _____

School phone: (____) _____

Is your child mainstreamed with typical-hearing students? **Yes** **No** **Unsure**

Does your child have an interpreter in the classroom? **Yes** **No** **Unsure**

Does your child have an Individualized Education Plan (IEP or 504)?
Yes **No** **Unsure**

7. HEARING AID INFORMATION:

Brand of hearing aids that your child currently uses:

How often does your child wear hearing aids?

Are there periods of the day that the hearing aids are not worn? **Yes No**
If yes, when? _____

Does your child wear the hearing aids willingly? **Yes No**

Does your child ever take off the hearing aids and/or refuse to wear them? **Yes No**
What do you do when this happens? _____

Does your child lose/damage the hearing aids on purpose? **Yes No**
What do you do when this happens? _____

At home, who takes care of the hearing aids? (Replacing batteries, cleaning, etc.)

At school, who takes care of the hearing aids? (Replacing batteries, cleaning, etc.)

Does your child use an FM system at school? **Yes No**

Will you or your child need an interpreter for the evaluation? **Yes No**
If so, what type? _____

Is there anything else that you would like us to know about your child?

Please note, here, if you have talked with your insurance carrier (private insurance only) and if they consider cochlear implants to be a "covered benefit". _____

*****If you have not checked with your insurance on this matter, you must do so before any appointments will be scheduled.***

Thank you for taking the time to complete this form.

**Please return to:
(your) CI Audiologist
Children's Hospital Medical Center,
3333 Burnet Ave.
MLC 2002
Cincinnati, OH 45229**