Stony Brook Medicine

STONY BROOK UNIVERSITY MEDICAL CENTER

AUDITORY PROCESSING CASE HISTORY FORM FOR ADULTS

You must bring a prescription from your physician on the first day of the appointment or we will not be able to perform the test.

TODAY'S DATE: _____

NAME: _____ DOB: _____

ADDRESS:_____
CITY:_____ZIP**:**_____
PHONE (H): _____ (W): _____(C): _____
E-MAIL _____
OCCUPATION_____
INSURANCE: _____ REFERRAL NEEDED? Y N

A REPORT WILL BE SENT TO THE REFERRING PHYSICIAN AND HOME IN APPROXIMATELY 10-14 DAYS.

Referred by _____
Person completing form □ Patient □ Spouse Other- Name _____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

Name	Relationship to patient	Address	phone	fax
Name	Relationship to patient	Address	phone	fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.
Signature of □ Patient □ Parent/Guardian _____ Date _____
Printed Name of Parent/Guardian _____

Name: _____ DOB: _____

What type of difficulties have you been experiencing?_____

_____

_____

Have you been evaluated for APD in the past?_____

_____

Have you received any other professional evaluations? (i.e. speech pathologist, neurologist,psychologist,etc) _____

_____

If so, **Please include a copy of all results with this form.**

When did you first become concerned?_____

_____

Do you have a documented hearing loss? YES_____ NO_____ If yes, please describe

_____

Difficulty hearing in background noise	YES_____	NO_____	SOMETIMES_____
Hear better when watching the speaker	YES_____	NO_____	SOMETIMES_____
Are you easily distracted?	YES_____	NO_____	SOMETIMES_____
“Ignore people”, especially if engrossed	YES_____	NO_____	SOMETIMES_____
Do you often need information repeated?	YES_____	NO_____	SOMETIMES_____
Difficulty remembering long instructions	YES_____	NO_____	SOMETIMES_____
Difficulty following conversations	YES_____	NO_____	SOMETIMES_____
Difficulty with rapid speech	YES_____	NO_____	SOMETIMES_____
Need more time to process information	YES_____	NO_____	SOMETIMES_____
Confuse similar sounding words	YES_____	NO_____	SOMETIMES_____
Poor Memorization skills	YES_____	NO_____	SOMETIMES_____
Difficulty taking notes	YES_____	NO_____	SOMETIMES_____
Spelling, reading, writing issues	YES_____	NO_____	SOMETIMES_____
Talk or likes TV louder than normal	YES_____	NO_____	SOMETIMES_____

AUDIOLOGIST COMMENTS (FOR OFFICE USE ONLY):

_____

_____

_____

_____

Audiologist signature _____ID# _____ Date/Time:_____