Children's Mercy

Hearing and Speech Questionnaire

(Page 1 of 4)

7093-058 MR 07/16

OFFICE USE ONLY: Medical Record Number: _____

Appointment Type: ☐ *SPEV* ☐ *PERSP* ☐ *Hearing* ☐ *Voice* ☐ *Reading* ☐ *Stuttering* ☐ *VCD/Cough* ☐ *Other:* _____

Mailed: ____/____/____ *Received:* ____/____/____ *Schedule Date:* ____/____/____

Appointment Date: _____/_____/_____ **Time:** _____:_____ ☐ **AM** ☐ **PM**

YOUR VISIT IS SCHEDULED AT THE LOCATION CHECKED BELOW:

☐ **Scottish Rite Temple**
1330 E Linwood Blvd
Kansas City, MO 64109
Phone: 816-561-2277 ext 108

☐ **Children's Mercy Kansas College Boulevard Clinics**
5520 College Blvd
Overland Park, KS 66211
Phone: (913) 696-5750
Fax: (913) 696-5761

☐ **Children's Mercy Northland**
501 NW Barry Road
Kansas City, MO 64155
Phone: (816) 413-2500
Fax: (816) 234-3291

☐ **Children's Mercy Broadway**
3101 Broadway
Kansas City, MO 64111
Phone: (816) 960-4001
Fax: (816) 302-9913

☐ **Children's Mercy East**
20300 Valley View Pkwy
Independence, MO 64057
Phone: (816) 478-5200
Fax: (816) 478-5993

BEFORE YOUR APPOINTMENT:

- Complete and return this questionnaire and any attached forms. **In the provided envelope, mail:**
  - ✓ This questionnaire, with all sections filled out as thoroughly as possible, and all enclosures.
  - ✓ Other forms included with this questionnaire, also completed:
    Copies of any hearing tests, speech reports, or other school reports that will help us know your child;
  - ✓ A recent picture of your child, if available.
- If you prefer to register online, just go to http://www.childrensmercy.org/ and click on *Parents & Children*, then click on *Pre-Registration*. Finally, choose *Hearing and Speech Clinic* or *Hearing & Speech* from the appropriate drop-down menu. Complete the registration form at least one week before your visit.
- If you have commercial insurance: Verify coverage. Have your physician complete all necessary referral or authorization forms. Fax to the number shown for the location of your appointment. You may also send or bring them with your other paperwork.
- The Children's Mercy Hospital ("CMH") accepts Medicaid.
- Contact the CMH Financial Counseling office at (816) 234-3567 to discuss additional options.
- Arrange child care for any other children.

ON THE DAY OF YOUR VISIT:

- Allow a full 2-3 hours for your visit.
- Feed your child before coming or bring a snack.
- You will be asked to remain with your child and to provide input during the evaluation.

You will be able to discuss the results of the testing and any recommendations with the speech pathologist on the day of your appointment.

Child's Name: _____

Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female Language: _____

Child's Name: _____

GENERAL INFORMATION

Address: _____
Street City State Zip

Home Phone Number: (____)_____-_____ Alternate Phone Number: (____)_____-_____

Father/Guardian: _____ **Language:** _____

Age: _____ Living in the Home? ☐ No ☐ Yes

Highest School Grade Completed: _____ Occupation: _____ Employer: _____

Home Phone: (____)_____-_____ Work Phone: (____)_____-_____ Other Phone: (____)_____-_____

Mother/Guardian: _____ **Language:** _____

Age: _____ Living in the Home? ☐ No ☐ Yes

Highest School Grade Completed: _____ Occupation: _____ Employer: _____

Home Phone: (____)_____-_____ Work Phone: (____)_____-_____ Other Phone: (____)_____-_____

Emergency Contact/Relationship to Child: _____ Phone Number: (____)_____-_____

Brothers and Sisters:

Name	Sex	Age	Living in the Home?	Problems Past or Present
_____	☐ Male ☐ Female	_____	☐ No ☐ Yes	_____
_____	☐ Male ☐ Female	_____	☐ No ☐ Yes	_____
_____	☐ Male ☐ Female	_____	☐ No ☐ Yes	_____

Primary Care Physician (PCP): _____ Office Phone Number: (____)_____-_____

Address: _____
Street City State Zip

Day Care/Preschool/School: _____ Phone Number: (____)_____-_____

Teacher/Contact Person: _____ Fax Number: (____)_____-_____

Address: _____
Street City State Zip

Referring Physician (if not PCP): _____ Office Phone Number: (____)_____-_____

Has your child been seen at Children's Mercy? ☐ No ☐ Yes (see below)

If yes, which clinic/unit and when? _____

REASON FOR VISIT

Describe the problem(s) that your child is having and when you first noticed: _____

_____

_____

_____

_____

What goals would you like to see accomplished as a result of this evaluation? _____

_____

_____

_____

_____

MEDICAL HISTORY

1. Current medications, including vitamins, herbal supplements, over-the-counter (list names and what for): ☐ None

_____

_____

_____

_____

Child's Name: _____

MEDICAL HISTORY (continued)

2. Allergies: ☐ No known allergies

_____

_____

_____

_____

3. Check all that apply to your child now or in the past:

- ☐ Asthma
- ☐ Attention deficit (hyperactivity) disorder (ADD/ADHD)
- ☐ Autism
- ☐ Behavior problem
- ☐ Breathing trouble, with or without exercise
- ☐ Clumsiness
- ☐ Ear pain or infection
- ☐ Easily distracted
- ☐ Emotional problem
- ☐ Feeding problem
- ☐ Frequent colds, sinus problems, or fluid drainage
- ☐ Frequent coughing
- ☐ Hearing problem or trouble listening or understanding under certain conditions
- ☐ Heartburn or reflux
- ☐ High fevers
- ☐ Hoarseness
- ☐ Inability or unwillingness to sit still
- ☐ Lack of coordination
- ☐ Lack of playmates (or playmates his or her age)
- ☐ Learning disability or slow learner
- ☐ Multiple handicaps (list below)
- ☐ Not following directions
- ☐ Poor memory (forgetfulness)
- ☐ Seasonal allergies (hay fever)
- ☐ Speech or language problem (i.e. difficult to understand; trouble reading or spelling)
- ☐ Stuttering
- ☐ Temper tantrums
- ☐ Upper respiratory illness/infections
- ☐ Vision problem
- ☐ Other health problem or major illness

4. Describe any concerns with items checked above and provide the information below for specialists somewhere other than CMH.

- Name of specialist or service provider: _____
  Type of professional or specialist: ☐ Counselor/Psychologist ☐ Psychiatrist ☐ Physical/Occupational Therapist ☐ Audiologist ☐ Speech/Language Pathologist ☐ Other: _____
  Phone: (_____)_____-_____ Address: _____
  Type of evaluation, testing, and/or treatment services: _____
  What for? _____
  When and how long were services provided? _____
  Results: _____
- Name of specialist or service provider: _____
  Type of professional or specialist: ☐ Counselor/Psychologist ☐ Psychiatrist ☐ Physical/Occupational Therapist ☐ Audiologist ☐ Speech/Language Pathologist ☐ Other: _____
  Phone: (_____)_____-_____ Address: _____
  Type of evaluation, testing, and/or treatment services: _____
  What for? _____
  When and how long were services provided? _____
  Results: _____

5. Has your child been hospitalized? ☐ No ☐ Yes, explain: _____

_____

_____

6. Has your child had surgery? Check and give dates for all that apply:
   ☐ Tonsillectomy: ____/____/____ ☐ Ear tubes: ____/____/____ ☐ Adenoidectomy: ____/____/____
   ☐ Other: _____, ____/____/____ ☐ Other: _____, ____/____/____

Child's Name: _____

MEDICAL HISTORY (continued)

7. Have any of your child's relatives had any of the following? (Check and explain all that apply.)
   - ☐ Hearing problems or hearing loss: _____
   - ☐ Speech or language problems: _____
   - ☐ Reading or learning problems: _____

BIRTH HISTORY AND GENERAL DEVELOPMENT

1. Child's birth weight: _____ lbs _____ oz
2. Check all that apply: ☐ Full term ☐ Premature, _____ weeks ☐ Normal delivery ☐ Cesarean
3. Did the mother have complications or health problems during pregnancy? ☐ No ☐ Yes, describe: _____
   _____
4. Did your child have trouble learning to suck as a newborn? ☐ No ☐ Yes, explain: _____
   _____
5. Check each developmental milestone your child has reached, and write what age your child first did each one:
   - ☐ Sit alone: _____ ☐ Walk alone: _____ ☐ Eat with a spoon: _____
   - ☐ Drink from a bottle: _____ ☐ Drink from a cup: _____ ☐ Eat table food: _____ ☐ Feed self: _____
   - ☐ Fasten buttons: _____ ☐ Take off coat: _____ ☐ Dress self: _____
   - ☐ Follow simple directions: _____ ☐ Respond to his/her name: _____
   - ☐ Say first words (begin babbling): _____ ☐ Say "mama" or "dada" with meaning: _____
   - ☐ Use 2-3 word sentences: _____
   - ☐ Describe activities to others: _____ ☐ Engage in conversations: _____
6. Were there any concerns about your child reaching developmental milestones? ☐ No ☐ Yes, explain: _____
   _____
7. How often do you read to your child? ☐ 1-2 times per day ☐ 1-2 times per week ☐ 1-2 times per month
8. Is your child toilet-trained? ☐ No ☐ Yes (see below)
   If yes: When was training started? _____
   When was training completed? _____

_____ Signature of Person Completing This Form

_____ Printed Name of Person Completing This Form

_____ Relationship to Child

_____/_____/_____ Date

FOR STAFF USE DURING VISIT:

Pain Assessment: Is there pain now? ☐ No ☐ Yes, check one: ☐ See clinic record/notes. ☐ Referred to primary care provider (PCP).
Informant: ☐ Patient ☐ Parent ☐ Other ☐ See "Outpatient Pain Assessment and Management Record" (#7080-002).
Cultural/Religious Practices: ☐ None ☐ Yes: _____
Emotional/Family/Home Concerns: ☐ None ☐ Yes: _____
Barriers to Learning: ☐ None ☐ Vision ☐ Reading ☐ Hearing ☐ Language ☐ Learning Disability ☐ Other: _____
Learning Needs Identified: ☐ None ☐ Yes: _____
Reviewed By (signature/title): _____ Date: _____/_____/_____ Time: _____ hours