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Auditory Processing Questionnaire

Name: _____ Date: _____
Date of Birth: _____ Age: _____
School: _____ Grade: _____
Referral Source: _____ Primary Care Physician: _____

Psychological/Educational Evaluation Date: _____
Conducted by: _____

Patient's Native Language: _____ Handedness? Right or Left

	YES	NO
Noises in the ear, e.g., ringing or roaring?	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance of certain loud sounds?	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted?	<input type="checkbox"/>	<input type="checkbox"/>
Inattentiveness to sounds?	<input type="checkbox"/>	<input type="checkbox"/>
Problems paying attention to sounds?	<input type="checkbox"/>	<input type="checkbox"/>
Problems localizing where sound is coming from?	<input type="checkbox"/>	<input type="checkbox"/>
Problems hearing in noise or when others are talking?	<input type="checkbox"/>	<input type="checkbox"/>
Complains about loud sounds in the environment?	<input type="checkbox"/>	<input type="checkbox"/>
Confuses directions or can't follow commands?	<input type="checkbox"/>	<input type="checkbox"/>
Reverses words, number, letters, etc?	<input type="checkbox"/>	<input type="checkbox"/>
Asks speakers to repeat (e.g. Says "What?" or "Huh?")	<input type="checkbox"/>	<input type="checkbox"/>
Normal game playing skills?	<input type="checkbox"/>	<input type="checkbox"/>
Musically inclined?	<input type="checkbox"/>	<input type="checkbox"/>
Artistically inclined?	<input type="checkbox"/>	<input type="checkbox"/>
Muscle coordination problem?	<input type="checkbox"/>	<input type="checkbox"/>
Normal social interaction with age-matched peers?	<input type="checkbox"/>	<input type="checkbox"/>
Intensive care nursery after birth?	<input type="checkbox"/>	<input type="checkbox"/>

Auditory Processing Questionnaire

YES

NO

Learning disability?

If yes, please explain: _____

When diagnosed and by whom? _____

Speech and/or language disorder?

If yes, please explain: _____

When diagnosed and by whom? _____

Reading problem?

If yes, please explain: _____

When diagnosed and by whom? _____

Attention deficit disorder?

If yes, please explain: _____

When diagnosed and by whom? _____

Siblings or others in family with language
or learning problems?

If yes, please explain: _____

When diagnosed and by whom? _____

Does your child receive any Occupational Therapy (OT),
Physical Therapy (PT) or speech therapy?

If yes, please explain: _____

When diagnosed and by whom? _____

Comments *Please mention anything else you feel is important about your child:* _____

Thank you!

Reviewed by:

Modified 12/14/2006