Gold Pg 1

"Please print clearly"

BERRIEN COUNTY HEARING IMPAIRED PROGRAM
HEARING CENTER

Revised 03-10-15

DATE: _____ Male____ Female____ COUNTY: _____

NAME: _____ AGE: _____ BIRTHDATE: _____

#1
Parent/Guardian: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Home Phone: _____ Cell: _____

E-Mail : _____
Preferred method of contact: ☐ Phone ☐ E-mail

#2
Parent/Guardian: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Home Phone: _____ Cell: _____

E-Mail : _____
Preferred method of contact: ☐ Phone ☐ E-mail

Message Phone#: _____ Name & Relationship to child: _____

Other Children: _____ Age: _____ _____ Ages: _____
(Blood Related) _____ Age: _____ _____ Ages: _____
_____ Age: _____ _____ Ages: _____

Notes: _____

CHECK ALL THAT APPLY

____ Early On Hearing Screen ____Pass ____Fail
____ Speech Evaluation
____ Qualify for Services ____Yes ____No
____ School Hearing Test ____Pass ____Fail
____ Difficulty Hearing at Home
____ Speech and/or Language Delay
____ Receiving Special Education Services ____YES ____NO
____ Receiving Speech Therapy ____YES ____NO
If yes, where: _____
Therapist's name: _____
____ Developmental Delay
____ Problems in School. If yes, concerns:
_____
_____

FAMILY HISTORY

Permanent Hearing Loss as a child-either side of the family?
____YES ____NO
Who?(How related to the child) _____
The Cause of Hearing Loss? _____
Do they wear Hearing Aids? ____YES ____NO
Other Problems? _____

School: _____ Grade: _____

Teachers: _____

Notes: _____
_____
_____

HEALTH/DEVELOPMENTAL HISTORY

Exposure to second hand smoke? ____YES ____NO
Ear Infections: ____YES ____NO How Many? _____
How many in the last year? _____
Date last ear infection treated? _____
Tubes? ____YES ____NO How many sets? _____
When were the last tubes set? _____

Ear Doctor: _____

Started walking at what age? _____
Cold or Allergies? _____
Other Medical Conditions? _____
Any Hospitalizations since birth? _____
Current Medications _____
_____

Family Doctor Pediatrician: _____

Notes: _____
_____