***The* Hearing Doctor**
Brandy D. Vowell, Au.D.
Board Certified Doctor of Audiology
521 E. Main Street Jenks, OK 74037
(918) 779-7500 Fax: (918) 995-2333

Pediatric History Intake

Personal Information

Date of Intake:______________________________

Child's Name:______________________________ Date of Birth:______________________

Parent/Guardian:______________________________ Relationship: ______________________

Email:____

Occupation:______________________________ Employer:______________________________

Home Address:____

City:______________________________ State:________________ Zip:________________

Home Phone:__________________ Cell Phone:__________________ Work Phone:__________________

Name of Insurance Policy Holder:______________________________ Date of Birth:________________

Insurance Carrier:______________________________ Group Number: ______________________________

Member ID:______________________________

Child's School______________________________Grade______________Handedness: ☐ Right ☐ Left

Pediatrician's Information

Pediatrician:______________________________ Phone:______________________________

Address:____

City:______________________________ State:________________ Zip:________________

Send Report? ☐ Yes ☐ No

Notice of Parental/Guarantor Responsibilities

You are responsible for all the fees associated with the care your child receives.
Payment is expected at the time of the service unless other arrangements have been made in advance.
It is your responsibility to understand your benefits and all obligations set forth by your insurance company.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available. Signing below authorizes The Hearing Doctor/Brandy D. Vowell, AuD to have assigned benefits of all charges submitted and to receive payment directly from the insurance company, and acknowledges responsibility for payment of bill in full by insured if insurance does not cover 100% in a timely fashion. Patient is responsible for entire medical bill regardless of amount paid/allowed by insurance. I am aware that services not covered by my insurance may include the following: case history review, diagnosis and recommendations, counseling, wax removals, vestibular testing, tinnitus exams, hearing aid checks, OSHA/workers compensation reviews, and hearing protection. I hereby authorize The Hearing Doctor/Brandy D. Vowell, AuD to release all information necessary to secure payment from my insurance and to provide my family physician with results regarding my appointment as The Hearing Doctor/Brandy D. Vowell, AuD deems necessary.

By signing below, I acknowledge that have read and understood the above information.

______________________________ ______________________________
Print Patient Name Signature of Parent/Guardian

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Birth History

Name of Hospital:____

Prematurity: ☐ Yes ☐ No Gestational Age at Birth:____________weeks

Jaundice: ☐ Yes ☐ No

Complications during pregnancy/delivery:____

Medical attention following birth:____

Blood transfusion ☐ Yes ☐ No
Medications ☐ Yes ☐ No
Cleft Palate ☐ Yes ☐ No
Craniofacial Anomalies ☐ Yes ☐ No
C-Section ☐ Yes ☐ No
Lack of Oxygen ☐ Yes ☐ No
Please explain if you answered yes to any of the above:

____

____

Duration of labor:____

Did any family member smoke cigarettes in the household during pregnancy? ☐ Yes ☐ No

Did your child pass the newborn hearing screening? ☐ Yes ☐ No If no, which ear(s) failed? ☐ Right ☐ Left ☐ Both

Birth weight____

Family History

Is your child adopted? ☐ Yes ☐ No

Did/Does any family member have any of the following diagnoses?

	Mother	Father	Sibling	
Seizure Disorder	☐	☐	☐	
ADHD/ADD	☐	☐	☐	
Autism/PDD/Asperger's	☐	☐	☐	
Learning Disability	☐	☐	☐	
Language Disorder	☐	☐	☐	
Articulation Disorder	☐	☐	☐	
Hearing Loss	☐	☐	☐	Age related? ☐ Yes ☐ No
Auditory Processing	☐	☐	☐	
Dyslexia	☐	☐	☐	

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Developmental History

Did your child have delayed speech/language development? ☐ Yes ☐ No
Did your child have delayed motor development? ☐ Yes ☐ No
Did your child have sensory issues? ☐ Yes ☐ No
Did your child receive early intervention services? ☐ Yes ☐ No
If so:
☐ Speech therapy
☐ OT
☐ PT
☐ Sensory Integration
☐ Play Group

Hearing History

Does your child respond to sound consistently? ☐ Yes ☐ No
Do you feel you need to repeat things for your child in order to be understood? ☐ Yes ☐ No
Does your child say "what?" or "huh?" frequently? ☐ Yes ☐ No
Do you need to raise your voice in order for your child to respond? ☐ Yes ☐ No
Does your child like to sit close to the television, or does he/she turn up the volume? ☐ Yes ☐ No
Does your child appear to have difficulty understanding speech in background noise? ☐ Yes ☐ No
Has your child had a formal hearing test by an audiologist? ☐ Yes ☐ No
Did your child have any ear infections in the first 18 months of life? ☐ Yes ☐ No
If so, how many?___________
At what age did your child's first ear infection?___________
Has your child ever been seen by an Ear, Nose and Throat Specialist (Otolaryngologist)? ☐ Yes ☐ No
Has your child ever received pressure equalizing (ventilating) tubes for chronic ear infections? ☐ Yes ☐ No
How many sets of tubes?_________ At what age?__________
Does your child have a frequent runny nose? ☐ Yes ☐ No
Does your child have frequent colds? ☐ Yes ☐ No
Does your child have allergies?

Medical History

Does your child present with any of the following medical conditions?
☐ Head trauma/injury
☐ Seizure disorders
☐ Visual problems
☐ Syndrome___________________________
☐ High Fevers/Serious Illness
☐ Hospitalizations/Surgeries

Does your child interact well with others his/her own age? ☐ Yes ☐ No

Behavior problems? ☐ Yes ☐ No

Does your child currently take medication? ☐ Yes ☐ No

If so, please list on the back of this page or provide a copy for the chart.

Medication List

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Additional Comments/Observations/Concerns:

____

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