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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
ALL CHILDREN'S HOSPITAL

Cochlear Implant Program Supplemental Case History

Please Return to achaudcochlear@jh.edu

Today's Date: _____

Patient Name: _____ MR#: _____

Date of Birth: _____ Age: _____ Caregiver(s): _____

Address: _____

City, State & Zip: _____

Cell Phone: _____ Cell Phone: _____ Home Phone: _____

Email: _____ Primary Preferred Contact: ☐ Phone ☐ Email

Primary Language spoken in the home: _____ Interpreter Required: Yes No

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Is your child followed by a JHACH Audiologist? Yes No

If no, please provide this information on the last page of this form.

***Please provide a copy of the most recent hearing test(s) for audiologist to review before an appointment will be scheduled, if not followed at a JHACH facility.*

Does your child currently wear hearing aids? Yes No Please circle/Bold: Right ear Left ear Both ears

Does your child receive therapy that emphasizes hearing and spoken language development? Yes No Don't know

***Please provide a copy of the most recent speech and language treatment report for audiologist to review before an appointment will be scheduled, if not followed at a JHACH facility.*

If yes to any of the following, please note on the next page.

Does your child have any other conditions other than hearing loss such as traumatic brain injury, cerebral palsy, brain tumor, seizures, vision loss, diagnosis of autism, ADHD and/or any psychiatric concerns?

Do they receive Occupational, Physical, or ABA therapy?

Has the child ever been evaluated by a psychologist, psychiatrist, neurologist and/or developmental-behavioral pediatrician?

If yes to any of the above, please describe:

_____

_____

_____

_____

HEARING/AUDIOLOGICAL/LANGUAGE HISTORY:

Did your child pass the newborn hearing screening shortly after birth? Yes No

If yes, at what age was concern for hearing loss noted? _____

Did your child's hearing worsen over time? Yes No

Is there a known cause of hearing loss? _____

What is the primary communication mode of your child (if appropriate)?

□ Oral communication (spoken language)
□ American Sign Language (ASL) only
□ Total communication (spoken language and sign)
□ Cued speech

What is the communication mode of the parents/family?

□ Oral communication (spoken language)
□ American Sign Language (ASL) only
□ Total communication (spoken language and sign)
□ Cued speech

If your child uses sign language as their primary mode of communication, do all members of the household sign?
Yes No

Is there more than one spoken language in the house? Yes No

If yes, which language(s)? _____

If your child is under 3 years of age, are you receiving Early Intervention Services? Yes No

If yes, with whom and how often? _____

_____

_____

EDUCATIONAL HISTORY:

If your child does not attend school or is not followed by the DHH program, please use "N/A."

Age of child when first started school: _____ Current school name: _____

Current grade placement: _____ Deaf/Hard of Hearing (DHH) provider: _____

Type of classroom child is enrolled in:

_____

Is your child receiving any remedial help or therapy services through the school system? (Check all that apply):

□ Aural rehabilitation/Auditory training □ Speech/Language therapy □ Remedial reading
□ Physical therapy □ Occupational therapy □ Sensory integration therapy
□ Other (please explain): _____

Is an interpreter used in the classroom? Yes No

If yes, what type? _____

Is an auditory trainer/FM or Roger system used in the classroom? Yes No

If yes, please provide more information if known): _____

During the school hours, are the hearing aids removed? Yes No

If yes, when and why? _____

Rate the child's current academic performance: Upper 25% Middle 50% Lower 25%

Any additional comments you would like us to know about your child or family? _____

PROVIDER INFORMATION:

Primary Care Physician/Pediatrician: _____
Phone: _____

ENT Physician (first and last name): _____
Phone: _____
Mailing/Email Address: _____

Audiologist (first and last name): _____
Phone: _____
Mailing/Email Address: _____

Speech/Language therapist (first and last name): _____
Phone: _____
Mailing/Email Address: _____