Cochlear Implant Pediatric Questionnaire

Date: _____

Person completing this form: _____ **Relationship to patient:** _____

Child and Family Information

Child's Name: _____ Gender: ☐ Male ☐ Female

Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Language(s) spoken at home (and by child care providers): _____

Primary language used by child: _____

Do you need an interpreter for your appointment? ☐ Yes ☐ No

If yes, please specify type: ☐ Spanish ☐ American Sign Language (ASL) ☐ Signed English (SEE)

☐ Other: _____

Please provide the following information:		
	Mother	Father
Name:		
Address *(if different from above)*:		
Email Address:		
Home Phone:		
Cell Phone:		
Work Phone:		
Highest Grade Completed:		
Occupation:		
Place of Employment:		
Primary Language:		

What is the best way to contact your family during the day time? _____

(Please be aware that we are unable to send texts.)

Who are the most important people in your child's life?					
Name	Age	Gender	Lives with Child	Hearing Loss	Relationship
		M F	Y N	Y N	
		M F	Y N	Y N	
		M F	Y N	Y N	
		M F	Y N	Y N	
		M F	Y N	Y N	
		M F	Y N	Y N	
		M F	Y N	Y N	

With whom does your child spend most of his/her time?

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Understanding Your Child and Family

Your responses to these questions help us to get to know your family and help us to design your services to meet your family's needs.

1. How would you describe your child's personality or temperament? _____

2. What, if any, activities does your child participate in outside of the home? _____

3. What are your child's favorite activities and with whom? _____

4. Do you have any concerns about your child's development pertaining to/or in addition to hearing loss?

5. What effects have your child's hearing loss had on the family? _____

6. What do you see as your child's next steps in his/her development? _____

7. What are your greatest hopes for your child? _____

8. What are your greatest fears for your child? _____

9. What questions would you like answered during the cochlear implant candidacy evaluation? _____

10. On a scale of 1 to 10, how interested are you in getting a cochlear implant for your child and why?

11. a. Were you referred for this assessment? ☐ Yes ☐ No
    b. If yes, by whom? _____

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Hearing Related Medical History

1. a. Is there any hearing loss within your immediate or extended family? ☐ Yes ☐ No
   b. If so, for whom, what was the diagnosis, and at what age? _____

2. a. Did your child pass his/her newborn screening at the hospital? ☐ Yes ☐ No ☐ I don't know
   b. If no, which ear(s) did not pass? ☐ Right ☐ Left ☐ Both ☐ I don't know

3. At what age was your child's hearing loss first noticed? ____Years ____Months

4. At what age was your child's hearing loss first diagnosed? ____Years ____Months

5. If an Auditory Brainstem Response (ABR) evaluation was administered, when and where was it performed?

6. a. Do you know the cause of your child's hearing loss? ☐ Yes ☐ No
   b. If yes, please check all that apply:
   ☐ Syndrome: _____ ☐ Cytomegalovirus (*CMV*) ☐ Meningitis *(provide age)* _____
   ☐ Genetic: _____ ☐ Other: _____
   c. If the cause is genetic, was formal genetic testing completed? ☐ Yes ☐ No ☐ I don't know
   d. What were the results from the genetic testing? _____

7. a. Has your child had any ear infections or drainage? ☐ Yes ☐ No
   b. If yes, approximately how many ear infections has your child had? _____
   c. If yes, how were the ear infections treated? _____

8. What kind(s) of amplification devices has your child used? (please check all that apply)

Device	Age Device was Fit	Which Ear(s)	Age of Consistent Use	Device Brand/Model
☐ Hearing Aid	____ yr(s)____ mo(s)	R L	yr(s) mo(s)	
☐ CROS[1] or BiCROS[2]	____ yr(s)____ mo(s)	R L	yr(s) mo(s)	
☐ BCD[3]/AOD[4] (e.g., BAHA[5])	____ yr(s)____ mo(s)	R L	yr(s) mo(s)	
☐ FM System	____ yr(s)____ mo(s)	R L	yr(s) mo(s)	
☐ Never fit w/amplification				

[1]Contralateral Routing of Signal (CROS), [2]Bilateral CROS (BiCROS), [3]Bone Connection Device, [4] Auditory Osseointegrated Device (AOD), [5]Bone Anchored Hearing Aid

9. Who dispensed the device(s)? _____

10. Does your child wear the device(s) willingly? ☐ Yes ☐ No

11. How many hours do they wear their amplification device in a typical day? *(Please use table to the right)*

	Hearing Aid/AOD		FM System	
	Home	School	Home	School
Mon. - Fri.				
Sat. -Sun.				

12. If device use is limited, what prevents full-time device use? _____

13. a. Do you notice a difference in your child's vocalizations or responsiveness with or without the device(s) in use?
   ☐ Yes ☐ No
   b. If yes, please describe. _____

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Early Health History

1. a. The child being assessed is my: ☐ biological child ☐ adopted child ☐ foster child ☐ step child
   b. If your child is a foster child, what is the length of time in your home thus far? _____
   c. Who has legal guardianship of the child? _____
   d. If your child is adopted, what was the age at adoption? _____

2. a. If any of the following conditions were present during the pregnancy, labor, or delivery, please indicate below.
   (If the answer is no, please leave blank.)

	Yes	Not Sure		Yes	Not Sure
Alcohol exposure			Meconium aspiration		
Anoxia			Oligo- or polyhydramnios		
Cytomegalovirus (CMV)			Perinatal hypoxia or anoxia (Lack of oxygen)		
Gestational Diabetes			Poor weight gain		
Drug exposure			Post-Partum Depression		
Eclampsia			Prescription drugs		
Excessive bleeding			Preterm labor		
Fetal distress			Rash		
Feeding difficulties			Rh incompatibility		
Group B streptococcus			Rubella		
Herpes simplex			Smoking exposure		
High blood pressure			Syphilis		
Illness/fever			Toxemia		
Jaundice			Toxoplasmosis		
Confirmed viral meningitis *Type: (if known)* _____			Confirmed bacterial meningitis *Type: (if known)* _____		
Other: _____					

   b. Please explain any "yes" answers *(add additional pages if more explanation is needed)*:

3. a. The baby was born: ☐ Early ☐ On time ☐ Late Length of pregnancy: _____
   b. The baby was born: ☐ Feet first ☐ Head first ☐ Breech ☐ C-section
   c. Birth weight: _____ pounds _____ ounces Length: _____ inches
   d. Were you told the Apgar Scores? ☐ Yes ☐ No If yes, fill in the scores: _____ 1 min. _____ 5 min.

4. a. Were there any other complications or concerns for your child during labor & delivery? ☐ Yes ☐ No
   b. Please describe:

5. a. Did your child spend time in the Neonatal Intensive Care Unit (NICU)? ☐ Yes ☐ No
   b. If yes, how many days? ☐ 0-5 days ☐ 6-15 days ☐ more than 15 days Please specify: _____
   c. During your child's time in the NICU, was your child diagnosed or treated with any of the following:
   (If the answer is no, please leave blank.)

	Yes	Not Sure		Yes	Not Sure
High oxygen concentrations needed			Assisted ventilation		
Intracranial hemorrhage (brain bleeding)			Blood transfusions		
Extracorporeal Membrane Oxygenation (ECMO)			Feeding difficulties		
Loop diuretics (e.g., furosemide/Lasix)			Premature lung disease		
Aminoglycosides (e.g., gentamycin & tobramycin)			Heart defects		
Retinopathy of prematurity (eye or vision problem)			Other:		

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Medical History

Please list any surgeries, hospitalizations, accidents or injuries your child has had. Please provide details.

1. a. Ear surgeries: *(Specify right, left, or both ears)* _____

b. Other surgeries: _____

c. Hospitalizations: _____

d. Accidents/Injuries: _____

2. a. Has your child been diagnosed with or treated for any of the following? *(In no, please leave blank.)*

	Yes	Not Sure		Yes	Not Sure		Yes	Not Sure
Abdominal pain			Cytomegalovirus (*CMV*)			Meningitis		
ADD OR ADHD			Dental problems			Mental health problems		
Abuse			Developmental delays			Metabolic problems		
Allergies/asthma			Excessive drooling			Muscle problems		
Arthritis			Fine motor problems			Neurodegenerative		
Autism spectrum disorder			Feeding/Eating difficulties			Seizures/epilepsy		
Balance problems			Genetic syndromes			Sensory processing disorder		
Behavioral concerns			Gross motor problems			Sinus infection		
Blood disorder			Growth problems			Skeletal malformation		
Cancer			Heart problems			Skin problems		
Cerebral palsy			Hormone problems			Thyroid problems		
Cleft palate &/or lip			Ingested poisons			Tonsillitis		
Cognitive Delays			Joint or bone problems			Repetitive movements		
Concussion/head injury			Kidney problems			Urinary problems		
Craniofacial surgery			Learning disability			Vision problems		
Other: _____								

b. Please explain any "yes" answers: _____

3. If your child has received any other formal diagnoses not listed above, please describe below.

Behavior

1. Do you have any concerns regarding your child's behavior? ☐ Yes ☐ No
   If yes, what are/were your concerns? _____

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Development

1. a. Do you feel that your child's communication skills have developed: ☐ Quickly ☐ Typically ☐ Slowly
   b. Age of:
   Babbling _____ First words _____ Put words together _____
   Sitting alone _____ Walking _____ Toilet independently _____
2. a. Do you have any concerns about your child's physical development? ☐ Yes ☐ No
   b. If yes, Please describe: _____
3. a. Did your child babble or coo as an infant? ☐ Yes ☐ No
   b. Does the child use his/her voice consistently? ☐ Yes ☐ No
   c. Does the child attempt to imitate speech? ☐ Yes ☐ No
   d. Do your family members understand your child? ☐ Yes ☐ No
   e. Can others understand your child? ☐ Yes ☐ No ☐ Most can ☐ Some can ☐ Few can
   f. How does your child communicate with others? (Check all that apply)
   ☐ Speaks ☐ Gestures ☐ ASL ☐ Signed English ☐ Cued speech
   ☐ Picture Exchange ☐ Dynavox ☐ iPad ☐ Other: _____
4. What are your communication goals for your child? _____

Vision

1. Has your child ever had a vision test? ☐ Yes ☐ No
2. Does your child wear glasses? ☐ Yes ☐ No
3. If yes, does your child wear them regularly? ☐ Yes ☐ No
4. Is your child's vision corrected to normal? ☐ Yes ☐ No ☐ Not Sure ☐ NA
5. Is vision loss due to: (Check all that apply)
   ☐ Nearsightedness ("myopia" can see clearly up close but blurry in the distance)
   ☐ Farsightedness ("hyperopia" can see clearly in the distance but blurry up close)
   ☐ Diabetic Retinopathy ☐ Optic Nerve Hypoplasia ☐ Coloboma ☐ Neurological/Cortical Vision Impairment
   ☐ Retinitis Pigmentosa ☐ Other: _____

Temperament

1. Did/does your child enjoy cuddling? ☐ Yes ☐ No ☐ Sometimes
2. a. Is/was your child a fussy baby? ☐ Yes ☐ No ☐ Sometimes
   b. If yes, how intense was the fussiness? _____
   c. How long did the fussiness last? _____
   d. What helped make your baby less fussy? _____

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Sleeping

1. a. Do/did you have any concerns regarding your child's sleeping? ☐ Yes ☐ No ☐ Sometimes
   b. If you answered yes or sometimes, what are/were your concerns? Check all that apply:
   - ☐ No or short naps
   - ☐ Difficulty going to bed
   - ☐ Length of night sleep
   - ☐ Length of bedtime routine
   - ☐ Where the child sleeps/slept
   - ☐ Other (explain below)

   c. Explain: _____

Family Health History

1. a. If anyone in the child's family (parents, grandparents, aunts, uncles, cousins, or siblings) has been diagnosed with or treated for any of the following, please check the appropriate box and indicate the family member below?
   (If the answer is no, please leave blank.)

	Yes	Not Sure	Family Member		Yes	Not Sure	Family Member
Abdominal pain				Growth problems			
Abuse				Heart problems			
Alcoholism				Hormone problems			
Anemia				Joint or bone problems			
Allergies/asthma				Lung/breathing issues			
Birth defects				Muscle problems			
Blood disorder				Mental health concerns			
Cancer				Seizures/convulsions			
Drug abuse				Skin problems			
Ear Infections				Repetitive movements			
Eating issues				Vision problems			
Genetic syndromes							

   b. Please explain any "yes" answers and add any other health concerns: _____

2. a. Does anyone in the child's family have developmental delays, speech/language problems or other special learning needs?
   ☐ Yes ☐ No
   b. If so, who, what was the diagnosis, and at what age? _____

Immunizations and Medications

1. Are your child's immunizations up to date? ☐ Yes ☐ No
2. a. Has your child had any negative reactions to any medications? ☐ Yes ☐ No ☐ Not Sure ☐ NA
   b. If yes, please list the medication and the reaction. _____
3. What medications, herbs, or homeopathic remedies does your child take currently? _____
4. a. Is your child allergic to anything? ☐ Yes ☐ No
   b. If yes, what is he/she allergic to and what is the reaction? _____

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Evaluations & Services

1. a. Has your child ever had educational or developmental evaluations? ☐ Yes ☐ No
   b. If yes, what kind of evaluation(s)? _____
   c. When was the evaluation? _____
   d. By whom and where was/were the evaluation(s) conducted? _____
   e. What were the results? _____
2. Is your child currently receiving intervention services? ☐ Yes ☐ No
3. a. Does your child have a current Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP)?
   ☐ Yes ☐ No
   b. If there is a current IFSP, who is your service coordinator? _____
   c. How often and where does your child currently receive services and who provides them?

Type of Therapist or Teacher	Frequency	Age Services Began	Service Location
Teacher of the Deaf	___ sessions per ☐ week ☐ month ☐ year		
Speech Therapist	___ sessions per ☐ week ☐ month ☐ year		
Physical Therapist	___ sessions per ☐ week ☐ month ☐ year		
Occupational Therapist	___ sessions per ☐ week ☐ month ☐ year		
Services Coordinator	___ sessions per ☐ week ☐ month ☐ year		
Audiologist	___ sessions per ☐ week ☐ month ☐ year		

4. a. Are there any services that your child received previously that are no longer being provided? ☐ Yes ☐ No
   b. If so, where and when? _____
   c. Who provided the services? _____
   d. Please describe your satisfaction with the current and previous services provided? _____
5. a. Does your child currently attend daycare? ☐ Yes ☐ No
   b. Does your child currently attend school? ☐ Yes ☐ No
   c. Daycare/School: _____
   d. Current Grade: _____
   e. Teacher(s): _____
   f. Classroom Type/Supports: (please check all that apply) ☐ Mainstream ☐ Self-Contained Classroom
   ☐ Paraprofessional ☐ Interpreter ☐ FM System/Sound Field Amplification ☐ Preferential Seating
   ☐ Other: _____

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Additional Information

Please let us know if you wish to explore the following opportunities. Check all that apply.

- ☐ Meet a parent of a child who is deaf or hard of hearing who uses spoken language.
- ☐ Meet a parent of a child who is deaf or hard of hearing who uses sign language.
- ☐ Meet a parent of a child who is deaf or hard of hearing who has additional challenges besides hearing loss.
- ☐ Connect with Nebraska's Guide by Your Side Program.
- ☐ Meet a Deaf adult who does not use a cochlear implant and who communicates using American Sign Language.
- ☐ Meet an adult who is hard of hearing who wears hearing aids and who communicates using spoken language.
- ☐ Observe in Boys Town's Preschool Program for students who are deaf or hard of hearing.
- ☐ Observe listening and spoken language therapy sessions.
- ☐ Enroll in listening and spoken language parent coaching sessions.
- ☐ Enroll in sign language classes.
- ☐ Receive information on school district consultation services.
- ☐ Connect with Nebraska PTI (Parent Training Information).
- ☐ Connect to parent organizations that support ☐ spoken language ☐ sign language ☐ both
- ☐ Attend a Roots and Wings weekend retreat designed for parents of newly identified children with hearing loss.

Medical Records and Insurance Information

52. a. Pediatrician/Primary Care Physician: _____
    b. Location: _____
    c. Primary Insurance: _____ Secondary Insurance: _____
    d. Other: _____

53. Please complete and return the following items along with this form:

- ☐ Copy of audiogram
- ☐ Signed medical release form
- ☐ Copy of your insurance cards
- ☐ Immunization records
- ☐ Individual Family Service Plan (IFSP) (if applicable)
- ☐ Individual Educational Plan (IEP) (if applicable)

Send the most recent copies of the items listed above to:

Mailing Address:	Fax Number:	Email:
Patient Services Coordinator BTNRH/CCD - LLTC 555 N. 30th Street Omaha NE 68131	531-355-5028	CITeam@boystown.org

If you have any questions, call the Patient Services Coordinator at 531-355-5698

For Office Use Only:

Reviewing Physician's Name: _____

Date Reviewed: _____ Date Reviewed w/Team: _____

Clinicians Signature: _____