Intake Form

A. Identifying/Family Information

1. Subject ID: ____

2. Sex: ________________

3. Name by which your child is called: ____ 4. Birthdate: _ _ / _ _ / _ _

5. Child's birthplace (City, State): ____

6. Name of Birthing Hospital/Facility: ____

7. Address of Facility: ____

____

8. Date intake form was completed: _ _ / _ _ / _ _

9. We are encouraged by NIH (National Institutes of Health) to collect information on the ethnic background(s) of our subjects to ensure equal access to research opportunities. If you choose to respond, this information will be provided to NIH anonymously and in group numbers, however it is not a requirement that you respond. Please check all of the following that apply to your child. If you feel that a different ethnic category applies, check *Other* and specify the additional category.

White	
African-American or Black	
Hispanic, Latino or other Spanish origin	
American Indian or Alaskan Native	
Asian	
Native Hawaiian or Pacific Islander	
Other (specify:_____________________)	
Refused	

10. Parents/Guardians: ____

11. Address: ____

____
City State Zip Code

12. ______________________________voice or TDD?
Home Phone Number

13. _______________________________voice or TDD?
Work Telephone Number

14. ____
Cell Phone Number

15. ____
Email Address

16. Are the above name(s) and address what you want us to use for this project? ☐ Yes ☐ No
If no, please provide additional information and instructions:

____

____

17. Please provide the following information on the child's biological parents:

Name	Relationship	Age	Live with child?	Education	Occupation	Hearing Loss
	Bio-Mother		Y N			Y N
	Bio-Father		Y N			Y N

If child lives with both bio-parents, skip to #22. If not, answer #18-#21 accordingly.

18. If mother does not live in the home with [CHILD], how much contact does he/she have with mother?

No contact	
Occasional contact	
Frequent contact	
Refused	

19. About how many days has [CHILD] spent with his/her mother in the last month? ____________ (range 0-31)

20. If father does not live in the home with [CHILD], how much contact does he/she have with father?

No contact	
Occasional contact	
Frequent contact	
Refused	

21. About how many days has [CHILD] spent with his/her father in the last month? ____________ (range 0-31)

22. How many persons (adults and children) live in your household? ____________
(Definition of household is persons who live in the same housing unit at least five nights a week most weeks.)

23. Please list each adult (age 18 or older or younger than 18 if a parent) in the home and his/her relationship to [CHILD].
Note: If not evident by relationship to child, ask & put an asterisk (*) by the primary caregivers in the home.

Name	Relationship to child (use codes below)	Age	Education	Occupation	Hearing Loss
					Y N
					Y N
					Y N
					Y N

Key for adult relationships:

Biological Mother
Biological Father
Adoptive Mother
Adoptive Father
Stepmother
Stepfather
Foster Mother
Foster Father
Legal Guardian
Grandmother
Grandfather
Other Adult Relative: specify
Unrelated Adult: specify

Key to adult levels of education:

a	Completed elementary school
b	Completed junior high
c	Received General Education Diploma (high school equivalence)
d	Completed high school
e	Completed 1 or more years of technical/vocational school
f	Completed technical/vocational school
g	Completed 1 or more years of university/college
h	Bachelor's degree
i	Completed 1 or more years of graduate school
j	Master's degree
k	Course work completed for PhD, but no dissertation; Law degree without bar; Medical degree without internship completed
l	Ph.D.; Law degree with bar; Medical degree with internship completed

24. Please list each child (younger than age 18) in the home, his/her relationship to [CHILD], age, & grade.

Name	Relationship to Child (use codes below)	Age	Grade	Hearing Loss
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

Key for child relationships:

Full biological brother
Full biological sister
Half brother
Half sister
Adopted brother
Adopted sister
Step brother
Step sister
Foster brother
Foster sister
Cousin (female)
Cousin (male
Other related child: specify
Other unrelated child: specify

B. Etiology/Identification

We'd like to learn more about your child's hearing.

1. When was your child's hearing loss identified? ____ At newborn hearing screening

    ____ Identified later (specify age in months: _______)

2. If your child was identified via a newborn hearing screen, please indicate the results of the screening.

	Right Ear		Left Ear		Not Sure
AABR	☐ Pass	☐ Refer	☐ Pass	☐ Refer	☐
OAE	☐ Pass	☐ Refer	☐ Pass	☐ Refer	☐

3. If it was diagnosed later, at what age did you first suspect the hearing loss? _______ (in months)

4. What made you suspect it? _____________

5. At what age did your child receive his/her first diagnostic hearing evaluation or diagnostic ABR?

    ______ months _______ not sure

6. How many appointments did it take to diagnose the hearing loss? ___________

7. Who made the diagnosis? ____ Physician _____ Audiologist _____Other (please specify: ______________)

8. If the diagnosis was not made by a physician/medical doctor, were you referred to one? ☐ Yes ☐ No

9. If yes, what kind of doctor was it?

	Choose one
Family practitioner	
Pediatrician	
Ear, Nose & Throat Doctor (ENT)	
Other (specify: ____)	

10. Around the time the hearing loss was identified, were you or your child seen for any of the following?

	Yes	No	Not Sure
General counseling regarding hearing loss	Y	N	NS
Early Intervention services	Y	N	NS
Consultation regarding communication options for children with hearing loss	Y	N	NS
Genetic testing	Y	N	NS
Appointment with a Geneticist	Y	N	NS
Appointment with Ophthalmologist (eye doctor)	Y	N	NS
Appointment with Neurology	Y	N	NS

11. If you have seen or currently see an ENT doctor:

    a. What is his/her name? ____

    b. What is the name of the clinic or facility where the ENT practices?: ________________________________

12. Did your child have a medical evaluation for their hearing loss? ☐ yes ☐ no ☐ not sure

13. If yes, by whom?: Name of physician: ____

    Facility (name & address): ____

    ____

    ____

14. During this medical evaluation, were any of the following procedures conducted?

	Yes	No	Not Sure
Blood tests	Y	N	NS
EKG (heart tests)	Y	N	NS
X-Ray	Y	N	NS
Magnetic Resonance Imaging (MRI)	Y	N	NS
Computed Tomography (CT scan)	Y	N	NS

15. Has the cause of your child's hearing loss been identified? ☐ Yes (please specify: ___________________) ☐ No

16. How old was your child when hearing aids were fitted? _______Months _______was not fitted with hearing aids

17. At what age (in months) was your child's hearing loss confirmed? _______________

18. If more than one month passed between confirmation of hearing loss and fitting of hearing aids, please indicate the **primary** reason for the delay:

Delay in obtaining appointment for medical clearance for hearing aids	
Delay in obtaining approval for insurance or other 3rd party funding for hearing aids	
Hearing aids were not initially recommended (please specify reason) ____	
Difficulty obtaining clinic appointment for hearing aid fitting	
Family decided not to proceed with hearing aid fitting right away (please specify reason) ____	
Child had other medical conditions that prevented follow up for hearing aid fitting	
Child had recurrent ear infections or other middle ear problems	
Other (please specify) ____	

19. Did your child wear loaner hearing aids prior to being fit with his/her own hearing aids?

☐ Yes ☐ No ☐ Don't know ☐ Refused

20. If yes, how long did your child wear the loaner hearing aids?

3 months or less	
4 to 6 months	
7 months or longer (specify: _________months)	

21. What kind(s) of amplification devices has your child used? Please select the device(s) that he/she uses or has used in the past, when usage began, and the professional (i.e., Audiologist, Hearing aid Dispenser, etc) who fit the device:

Device	Check any that apply	Age device use began (months)	Monaural	Binaural	Fitter
Hearing Aid					
Baha					
FM System					
Never fitted with amplification					

22. What doctor provided medical clearance for the hearing aid(s)?

	Choose one
Family practitioner	
Pediatrician	
Ear, Nose & Throat Doctor (ENT)	
Other (specify: ______________________________)	

23. How were your child's hearing aids paid for? (check any that apply)

	First Set	Current Set
Private Pay ("Out of pocket")		
Private Insurance		
State Program		
Other (specify:___________________)		

24. Has your child's hearing loss changed since it was diagnosed? ☐ Yes ☐ No ☐ Not sure

25. If yes, please describe how it has changed:

26. Has your child had tubes placed in his/her eardrums? ☐ Yes ☐ No

27. If yes, how many SETS of tubes have been placed? _______sets

C. Childcare Information

1. Since your child was born, has [he/she] ever been regularly cared for by someone other than a parent or guardian? By regular, we mean for more than 10 hours a week most weeks. This includes child care while a parent or guardian works or goes to school, as well as preschool or nursery school. ☐ Yes ☐ No ☐ Don't know ☐ Refused

2. If Yes, when your child is/was in child-care, where is/was that generally provided?

[CHILD'S] home,	
Someone else's home, or	
A child-care center	
Other (specify: ________________________________)	
Child's home and another home	
Don't Know	
Refused	

3. Currently, during a typical weekday, how many hours does your child spend in each of these settings? If child is younger than school age, complete first column only. If school age, complete both columns.

Setting	# of hrs/day in school year	# of hrs/day in summer
At home		
Childcare / Daycare		
Preschool		
Kindergarten or Elementary School		
Home School		
Other (specify:__________________________________)		

D. Early Intervention Services for Your Child

In this next section, I would like to talk about your experiences with early intervention or therapy services for [CHILD]. [If the child is Birth-to-Three years old these questions will be about their current services. If the child is older than three years these questions will be about services the family received in the past. Please ask all questions in this section for ALL children who have received early intervention services.]

1. Is/was your child eligible for early intervention services in your state? ☐ Yes ☐ No ☐ Don't know ☐ Refused
   If no, complete 1a & 1b and then skip to Section E.

   a. If not, why not? ____

   b. Who decided? ____

2. If eligible, are/were early intervention services provided?

   ☐ Yes ☐ No If no, why not? ____

a. If your child is/was eligible, was hearing loss the primary reason for his or her eligibility?

☐ Yes ☐ No ☐ Don't know ☐ Refused

b. If No, specify what eligibility is/was based upon: ____________________

3. How much effort did it take to find out about how to get early intervention services for your child? Would you say it took (... NOTE: EFFORT MIGHT ENTAIL ASKING PEOPLE ABOUT WHAT COULD BE DONE FOR THEIR CHILD, ASKING ABOUT TESTING, CALLING PLACES TO TRY AND GET INFORMATION ABOUT SERVICES, ETC.)

		Comments:
A lot of effort to find out where to go	☐	
Some effort,	☐	
Little effort, or	☐	
No effort at all?	☐	
Don't know	☐	
Refused	☐	

4. How many months old was your child when early intervention services began?
PROBE FOR A WHOLE NUMBER OF MONTHS.

		Comments:
Less than 1 month	☐	
Months: _____ (Range = 1-41)	☐	
Don't know	☐	
Refused	☐	
Other	☐	

5. Once you contacted early intervention services, about how long was it before services started?
PROBE FOR WHOLE NUMBERS IN MONTHS. ROUND IF NECESSARY.

Less than one month	
One month	
Two months	
Three months	
More than three months	
Haven't started services yet	
Don't know	
Refused	

6. Are/were you aware of a written plan describing goals for your child and the services [he/she] should receive/have received? It may have been called an IEP, IFSP, Child and Family Service Plan, or something like that.
NOTE: IFSP STANDS FOR "INDIVIDUALIZED FAMILY SERVICE PLAN."

Yes	
No	
Don't Know	
Refused	

7. Who decided the goals or "outcomes" for your child on [his/her] service plan? Was it:

Mostly your family	
Mostly the professionals	
You and the professionals together	
Don't Know	
Refused	

8. Who decided on the kinds of services for your child? Was it:

Mostly your family	
Mostly the professionals	
You and the professionals together	
Don't Know	
Refused	

9. Who decided on the amount of services for [CHILD]? Was it:

Mostly your family	
Mostly the professionals	
You and the professionals together	
Don't know	
Refused	

10. How would you rate the amount of intervention services your child is/was receiving? Would you say it is/was:

More than needed	
About the right amount	
Less than needed	
Enough of some, but not others (please comment below)	
Don't know	
Refused	

Comments: ____

11. How did you feel about the decisions regarding the services your child would receive?

I felt very good about the decisions that were made	
I felt some of the decisions were good	
I 'm not sure	
I did not like the decisions that were made	
I was very unhappy about the decisions that were made	

12. How did you feel about your involvement in the decisions regarding your child's services? Do/did you feel you:

Wanted to be more involved	
Were involved about the right amount	
Wanted to be less involved	
Don't Know	
Refused	

13. Have there been services your child needed but did not receive?

- ☐ Yes (please specify:____)
- ☐ No
- ☐ Don't Know
- ☐ Refused

14. Is/was a case manager, team leader or services-coordinator involved in your child's early services? This person typically leads IFSP or IEP meetings, determines how much service the child receives and is the primary contact for the family. She/he may be a teacher, SLP or other professional.

☐ Yes ☐ No ☐ Don't Know ☐ Refused If other than "Yes" Skip to Question $E_{1.}$

15. If yes, how often do/did you meet with the Services Coordinator? Would you say it is/was approximately:

Twice a month	
Once a month	
Every other month	
Two-three times per year	
Once a year	
Don't know	
Refused	

16. How helpful is/was this service?

Not helpful	
Helpful	
Very Helpful	

E. Your Child's Current Services

1. Is your child currently receiving services related to hearing and communication?

☐ Yes ☐ No ☐ Don't know ☐ Refused

If any response except "yes" skip to Section F

2. How often and where do they receive services and who provides them? For example, some children see a teacher of the deaf/hard-of-hearing twice a week at school. Other children might see a speech-language pathologist once a week at home. The therapist might be a speech-language pathologist, teacher of the deaf and hard-of-hearing or sign language instructor for example.

Type of Therapist or Teacher (SLP, Teacher of the Deaf)	**Frequency**	**How long is an average session (minutes)**	**Where**
	____ sessions per month *or* ☐ seen less than monthly		
	____ sessions per month *or* ☐ seen less than monthly		
	____ sessions per month *or* ☐ seen less than monthly		
	____ sessions per month *or* ☐ seen less than monthly		

3. Who are the current professionals providing services to your child? Please provide the name, address, phone number and email address of the hearing aid specialist, audiologist, early interventionist, teacher, speech pathologist or any other therapist working with your child.

Name	Professional Role	Address	Phone	**Email**

F. Medical & Developmental Information/Birth History

1. Length of pregnancy **in weeks** __________________ ☐ Don't Know

2. Birth Weight ______pounds & ______ounces ☐ Don't Know

3. Was [CHILD]: ☐ Full-term ☐ Premature ☐ Not sure

4. Were there complications/maternal illnesses during the pregnancy with your child? ☐ Yes ☐ No ☐ Don't know
If yes, please describe:

5. Were medications taken during the pregnancy? ☐ Yes ☐ No ☐ Don't know
If yes, please describe:

6. Were there any concerns for your child's growth or movement during the pregnancy? ☐ Yes ☐ No ☐ Don't know
If yes, please describe:

7. Was your child exposed to the following infections during pregnancy, during delivery, or after birth?

	Yes	**No**	**Not Sure**
Cytomegalovirus (CMV)	Y	N	NS
Herpes simplex	Y	N	NS
Rubella	Y	N	NS
Syphilis	Y	N	NS
Toxoplasmosis	Y	N	NS
Group B streptococcus	Y	N	NS
Confirmed bacterial meningitis (type: __________________)	Y	N	NS
Confirmed viral meningitis (type: __________________)	Y	N	NS
Other (specify: ____________________________________)			

8. Were there any of the following complications associated with the pregnancy or labor and delivery?

	Yes	No	Not Sure
Eclampsia	Y	N	NS
Fetal distress	Y	N	NS
Oligo- or polyhydramnios	Y	N	NS
Bleeding	Y	N	NS
Rh incompatibility	Y	N	NS
Premature rupture of membranes	Y	N	NS
Preterm labor	Y	N	NS
Perinatal hypoxia (lack of oxygen)	Y	N	NS
Meconium aspiration	Y	N	NS

9. Were there any complications or concerns for your child during labor and delivery? ☐ Yes ☐ No
If yes, please describe:

10. Did your child have any of the following treatments?

	Yes	No	Not Sure
Extracorporeal Membrane Oxygenation (ECMO)	Y	N	NS
Assisted ventilation	Y	N	NS
High oxygen concentrations needed?	Y	N	NS
Aminoglycosides (such as gentamycin & tobramycin) Specify name/type:_____________________________	Y	N	NS
Loop diuretics (such as furosemide/Lasix)	Y	N	NS
Chemotherapy	Y	N	NS
Blood transfusions?	Y	N	NS

11. Did your child spend time in the Neonatal Intensive Care Unit (NICU)? ☐ Yes ☐ No

12. If yes, how many days? _____0-5 days _____6-15 days _____more than 15 days (please specify: _____ days)

13. During your child's time in the hospital, was or were there:

	Yes	No	Not Sure
Intracranial hemorrhage (brain bleeding)?	Y	N	NS
Necrotizing enterocolitis (NEC)?	Y	N	NS
Retinopathy (eye or vision problem) of prematurity?	Y	N	NS
Heart defects? What type?: ___________________________	Y	N	NS
Premature lung disease?	Y	N	NS

14. Did your child stay in the hospital (but not the NICU) after the birth because of medical problems?

☐ Yes ☐ No
If yes, please explain:

15. Was your child jaundiced? ☐ Yes ☐ No ☐ Not Sure

16. If yes, how high was the bilirubin concentration?: ___________________________ ☐ Not sure

17. How was the jaundice treated? (check all that apply)

Treatment		For how long (days)?
Bilirubin lights		
Exchange transfusion		
Other (specify: ______________________________)		
Not sure		

18. Did your child have kernicterus, a form of brain damage caused by excessive jaundice?

☐ Yes ☐ No ☐ Not Sure

19. Did your child receive any other medications or treatments at birth that we have failed to ask you about?

☐ Yes ☐ No ☐ Not Sure
If yes, please explain:

20. Does your child have a place to go for regular medical care where they know him/her and his/her medical history? [Note: regular medical care includes check-ups as well as where the child goes when he or she is sick.]

☐ Yes ☐ No

21. Where does your child go for regular medical care?

	Choose One
Private physician/pediatrician	
Public health clinic	
Specialized clinic/office (i.e., ENT office)	
Hospital	
Urgent care	
Other (specify:____)	

22. When was your child last seen for a regular health/medical check-up (in months)?

_________months since last check-up ☐ Has never been seen ☐ Not Sure

23. Is your child covered by any kind of health insurance? ☐ Yes ☐ No

24. If yes, what is the source of this health insurance?

Health insurance through employer or purchased directly	☐
Government assisted health insurance program (i.e., Medicaid)	☐
HMO	☐
Other (specify:____)	☐

25. Have you had to change insurance plans or buy extra insurance for your child because of his/her hearing loss?

☐ Yes ☐ No

26. Have you ever tried to get your insurance or health plan to pay for something for your child but they wouldn't pay?

☐ Yes ☐ No

27. If yes, what wouldn't your insurance pay for? (Choose all that apply):

Diagnostic procedure or test	☐
Surgery	☐
Hearing Aids	☐
FM	☐
Therapy Services	☐
Prescriptions/Medications	☐
Or something else? (please specify: ________________________)	☐
Don't Know	☐

28. Is your child's general health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

29. Does your child have any chronic health conditions? ☐ Yes ☐ No
If yes, what?

30. Is your child currently under medical treatment? ☐ Yes ☐ No
If yes, for what?

31. Is your child currently taking any prescribed medications? ☐ Yes ☐ No
If yes, please complete the following:

NAME OF MEDICATION	DOSAGE/AMOUNT	REASON FOR MEDICATION	HOW LONG ON MED?

32. Do you have any concerns about your child's health at this time? ☐ Yes ☐ No
If yes, please explain:

Please ask the interviewee to complete the last two pages of this form completely and return.

Has your child had or been diagnosed with any of the following?

	Yes	No	Not Sure	Specify
ADD or ADHD				
Autism spectrum disorder				
Cerebral palsy				
Syndrome associated with hearing loss (specify)				
Neurodegenerative disorder associate with hearing loss (specify)				
Permanent neurological disorder from a stroke or head injury (specify)				
Seizures				
Epilepsy				
Feeding or swallowing difficulty (specify)				
Heart problems (specify)				
Kidney problems (specify)				
Thyroid problems (specify)				
Ear Surgery other than “tubes” (specify)				
Cleft palate and/or lip (specify)				
Craniofacial surgery				
Arthritis (childhood or young adult)				
Skeletal deformity (specify)				
Muscle disorder (specify)				
Fine motor problems				
Gross motor problems				
Balance problems				
Sensory Processing Disorder (Sensory Integration difficulties)				
Cognitive Delays (specify)				
Learning Disability (specify)				
Developmental problem or delay (specify)				
Other medical conditions (specify)				

VISION

	Yes	No	Not Sure	Specify
Has your child had his/her vision tested?				
Does your child wear eyeglasses?				
If yes, is child’s vision corrected to normal?				
If child wears glasses, is he/she nearsighted?				
If child wears glasses, is he/she farsighted?				
Does your child wear his/her glasses consistently?				
Has your child had eye surgery? (specify)				
Has your child been diagnosed with Retinitis Pigmentosa (RP)?				

G. Household Information

In studies like these, households are sometimes grouped according to income. Please select the group that best describes the total income of all the persons in your household over the past year. Include salaries or other earnings, retirement, public assistance, and so on.

1. Please identify the range that is closest to your household income BEFORE TAXES:

Income Range	
$5,000, or less	
$5,001. to $10,000.	
$10,001. to $15,000.	
$15,001. to $20,000.	
$20,001. to $25,000.	
$25,001, to $30,000.	
$30,001 to $35,000.	
$35.001. to $40,000.	
$40,001. to $45,000.	
$45,001. to $50,000.	
$50,001, to $60,000.	
$60,001 to $70,000.	
$70.001. to $80,000.	
$80,001. to $90,000.	
$90,001. to $100,000.	
$100,001. To $125,000.	
Over $125,000.	
REFUSED	

2. Name of person completing this form: ____

3. Relationship to child: ____

4. Can you legally sign consent forms for this child? ☐ Yes ☐ No

5. Do you have scheduling preferences, such as particular days of the week or times of day?

6. We don't want to lose track of you. Could you please list the name, address and telephone number(s) of someone (family or friend) who is likely to know where you are if we cannot reach you?

Name: ____

Address: ____

____
City State Zip Code

____________________ ____________________
Home Phone Number Work or Cell Phone Number

Relationship to child: ____

Office Use Only:

OCHL staff person conducting this interview accepting this form: ______________________