

**HEARING CENTER OF THE MIDWEST  
COCHLEAR IMPLANT PROGRAM  
Parent Questionnaire**

**I. Identification**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Sex: F M  
Parent's Names: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_ Work Phone: \_\_\_\_\_

**II. Hearing Loss Information**

1. When did your child lose his/her hearing? \_\_\_\_\_

2. What was the cause of your child's hearing loss?

\_\_\_ Genetic/ Hereditary      \_\_\_ Syndrome (\_\_\_\_\_)  
\_\_\_ Meningitis (at age \_\_\_)      \_\_\_ Unknown

Other (please describe):

\_\_\_\_\_  
\_\_\_\_\_

3. At what age was your child's hearing loss identified?

Years \_\_\_\_\_ Months \_\_\_\_\_

4. Does your child wear hearing aid(s)? \_\_\_\_\_

5. Which ear does your child wear the aids on?

Right                      Left                      Both

Right:

Left:

Brand and Model: \_\_\_\_\_

Type: \_\_\_\_\_

Volume Setting: \_\_\_\_\_

Date of Purchase: \_\_\_\_\_

6. Is your child a consistent hearing aid user? \_\_\_\_\_

If not, why not? \_\_\_\_\_

7. Has your child ever worn a tactile aid? \_\_\_\_\_  
If so, which one? \_\_\_\_\_ For how long? \_\_\_\_\_

8. Does your child usually:

HA TA U (HA-hearing aids; TA- tactile aids; U- unaided)  
\_\_\_\_ Respond to speech sounds (e.g., name being  
called from 3 to 9" hear speech over the phone)  
\_\_\_\_ Discriminate 1 to 2 syllables (e.g., ball, baby)  
\_\_\_\_ Play vocal games/imitate speech  
\_\_\_\_ Other. Please explain \_\_\_\_\_  
\_\_\_\_\_

9. When and where did your child have his/her last hearing test? \_\_\_\_\_  
\_\_\_\_\_

### III. Medical Information

1. Has your child ever had ear surgery? \_\_\_\_\_ Which ear? \_\_\_\_\_  
If yes, what was the date(s) of the surgery? \_\_\_\_\_  
Describe the surgery \_\_\_\_\_  
\_\_\_\_\_

2. Does your child have chronic ear infections or drainage? \_\_\_\_\_  
If so, please describe \_\_\_\_\_  
\_\_\_\_\_

3. Does your child have any chronic or ongoing medical conditions?  
\_\_\_\_ Tonsillitis                      \_\_\_\_ Sinus Infection  
\_\_\_\_ Allergies                          \_\_\_\_ Frequent Colds  
\_\_\_\_ Ear Infections                  \_\_\_\_ Seizures  
\_\_\_\_ Other \_\_\_\_\_

4. Does your child have any visual or physical problems? \_\_\_\_\_  
\_\_\_\_\_

5. Does your child have problems with balance or coordination? \_\_\_\_\_  
If so, please describe \_\_\_\_\_

6. Has your child even been hospitalized for other health reasons? \_\_\_\_\_  
If so, please describe \_\_\_\_\_

7. Has your child had any x-rays of his/her ears and/or head? (CT, MRI, etc.)  
\_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_  
Results: \_\_\_\_\_  
\_\_\_\_\_

#### IV. Communication Information

1. How does your child communicate?  
\_\_\_\_\_ Spoken English \_\_\_\_\_ Written Language  
\_\_\_\_\_ Total Communication (Sign System? \_\_\_\_\_)  
\_\_\_\_\_ American Sign Language \_\_\_\_\_ Cued Speech  
\_\_\_\_\_ Other (pleases describe \_\_\_\_\_)

2. Which best describes how your child expresses him/herself:  
\_\_\_\_\_ Vocalization \_\_\_\_\_ Gestures  
\_\_\_\_\_ Single words/signs \_\_\_\_\_ Two words/signs  
\_\_\_\_\_ Uses sentences of words/signs  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What mode of communication do you use with your child? \_\_\_\_\_  
\_\_\_\_\_

4. Does your child presently receive special services? \_\_\_\_\_  
Number of times per week \_\_\_\_\_  
Number of minutes per sessions \_\_\_\_\_

#### V. Educational Information

1. At what age did your child begin receiving professional services?  
Years \_\_\_\_\_ Months \_\_\_\_\_  
What services did they receive? \_\_\_\_\_  
\_\_\_\_\_

2. Name of child's present school and educational placement

\_\_\_\_\_ mainstreamed public school  
\_\_\_\_\_ combination of mainstreaming and special classes  
\_\_\_\_\_ self-contained class for hearing impaired  
\_\_\_\_\_ other, please describe \_\_\_\_\_  
\_\_\_\_\_

3. Please list ALL programs your child has attended:

School	City, State	Phone	Dates Attended	Type of Program
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Does your child wear an auditory trainer in school? \_\_\_\_\_  
If so, what brand and model? \_\_\_\_\_

5. Name and phone number of professionals currently serving your child

_____	( )	_____
_____	( )	_____
_____	( )	_____
_____	( )	_____

**VI. Family Data**

1. Please list information for members of the family:

Name	Relationship	Age	Occupation	Education
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**VII. Other information**

1. How were you referred to Hearing Center's cochlear implant program?  
\_\_\_\_\_  
\_\_\_\_\_

2. What do you hope for your child to gain with a cochlear implant?

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3. What are you current levels of satisfaction with:

	Very	Adequate	Poor
Child's mode of Communication	_____	_____	_____
Child's present school placement	_____	_____	_____
Child's present support services	_____	_____	_____
Child's overall academic progress	_____	_____	_____

Comments:

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4. Is there any other information you feel the Team should be aware of?

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5. Do you have any specific concerns or questions about a cochlear implant?

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Person completing questionnaire \_\_\_\_\_

Relationship to child: \_\_\_\_\_

**PLEASE ENCLOSE A COPY OF YOUR LAST AUDIOGRAM**