MIDWEST
EAR, NOSE & THROAT
"Feel better."

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?

____

____

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:

____

____

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

____

____

____

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

____

____

____

Person completing questionnaire ____________________________________

Relationship to child: __________________________________

PLEASE ENCLOSE A COPY OF YOUR LAST AUDIOGRAM