



QUESTIONNAIRE

Please fill in this form. This information is entirely confidential.

The following information will assist us in understanding your child and family's needs.

Referred by: _____ Today's Date: ____/____/____
Name & Title (if known) (month/day/year)

FAMILY INFORMATION

Child's Name: _____
(first & last)

Birthdate: (m/d/y) ____/____/____ Gender: ____M ____F

Address: _____ City: _____ PC _____

Please include information about all parents and/or guardians who have custody

Parent/Guardian: _____ Relationship to child: _____
(first & last name)

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

Address : _____ City: _____ PC _____
(if different from above)

Email address: _____ How often is it checked? _____

Parent/Guardian: _____ Relationship to child: _____
(first & last name)

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

Address: _____ City: _____ PC _____
(if different from above)

Email address: _____ How often is it checked? _____



Child's Name: _____

FAMILY INFORMATION continued

Other Children in the Family:

Name (first and last)	Date of Birth (month/day/year)
_____	___/___/___
_____	___/___/___
_____	___/___/___

Does anyone in your family have a hearing loss? If so, please list name, relationship and degree of loss.

Family Physician: _____ **Phone:** _____

Emergency contacts: (if parent/guardian unavailable)

first and last name	relationship	phone
first and last name	relationship	phone

Please check if any of these apply to your family:

Aboriginal **First Nations** **Métis**

Our program strives to respect diversity. If you think it will help us better serve your family, please provide the following optional information:

Language(s) at Home _____

Interpreter needed? _____

Cultural background: _____

Religion/Spiritual considerations: _____



Child's Name: _____

Questionnaire - Page 3

HEARING AND HEARING AIDS

What have you been told about your child's hearing loss (eg. severity, type)?

Has your child been fitted for hearing aids yet? Yes No

If yes, date of fitting: ____/____/____
m/d/y

Does your child wear his/her hearing aids? Yes No Frequency?:

Does your child have a Cochlear Implant? Yes No

If yes, date of implant ____/____/____
m/d/y

Is there anything else you want us to know about your child's hearing loss or your concerns in this area?

COMMUNICATION

How do you communicate with your child?

How does your child communicate with you? (eg. gestures, crying, pointing, facial expressions, sounds, talking, signing)

Is there anything else you want us to know about your child's communication or your concerns in this area?



Child's Name: _____

MEDICAL INFORMATION:

Are your child's immunizations up to date? Please circle all that apply.

Age at Vaccination	DTaP ¹	IPV	Hib ²	MMR	Td ³ or dTap ¹⁰	Hep B? (3 doses)	V	PC	MC
Birth									
2 months	x	x	x			Infancy or pre-adolescence (9-13 yrs)		x?	x ⁹
4 months	x	x	x					x	x
6 months	x	(x)?	x					x	x
12 months				x				x?	x
18 months	x	x	x						or
4 – 6 years	x	x			x ¹⁰				x ⁹

DTap	Diphtheria, tetanus, pertussis (acellular) vaccine
IPV	Inactivated poliovirus vaccine
Hib	<i>Haemophilus influenzae</i> type b to conjugate vaccine
MMR	Measles, mumps and rubella vaccine
Td	Tetanus and diphtheria toxoid, adult type with reduced diphtheria toxoid
dTap	Tetanus and diphtheria toxoid, acellular pertussis, adolescent/adult type with reduced diphtheria and pertussis components
Hep B	Hepatitis B vaccine
V	Varicella
PC	Pneumococcal conjugate vaccine
MC	Meningococcal C conjugate vaccine

Does your child have any allergies? Yes No If yes, describe:

Does your child have any chronic medical conditions? Describe and list any current medications:

Was there pre-natal exposure to alcohol _____, drugs _____, or tobacco _____

Does your child have any additional developmental challenges/ and or any other specific diagnosis in an area other than hearing loss? Yes No

If yes please describe:

Has your child's vision been tested by an Optometrist or Ophthalmologist? Yes No

If yes, Date: _____ Location: _____ Results: _____



Child's Name: _____

Questionnaire - Page 5

OTHER SUPPORT SERVICES

Is your child receiving services from any other individuals or programs? Check all that apply

- Infant Development Program
- Physiotherapy
- Occupational Therapy
- Visual Impaired Program
- Other: (list) _____
- Speech Language Therapy
- Supported Child Care/Development
- Preschool/ Daycare/Daycare

Are there any people in your life or community supports or resources that you have found helpful to your family? Please list here.

PLEASE SHARE ANY OTHER INFORMATION THAT YOU THINK WILL BE HELPFUL TO US?

I give my permission for my name to be added to a list of individuals who will receive future information, updates, and publicity from the BC Family Hearing Resource Centre.

Signature

Name (please print)

If you have decided to participate in services at the BC Family Hearing Resource Centre, please sign below:

I give permission to the BC Family Hearing Resource Society to provide services to my child and family.

Your Signature: _____ Date: _____

