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:_____

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

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

Address: _____City: _____ PC_____
(if different from above)

Email address:_____

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

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?* (Y or N)_____

Cultural background: _____ *Religion/Spiritual considerations:* _____

Please check if any of these apply to your family:

____Aboriginal ____First Nations ____Métis

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:____/____/____ **month/day/year**

Does your child wear his/her hearing aids? Yes ☐ No ☐ If yes, frequency?:_____

Does your child have a Cochlear Implant? Yes ☐ No ☐ If yes, date of implant ____/____/____ **month/day/year**

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?

_____

_____

MEDICAL INFORMATION:

Birth History: Birth Weight _____ Gestation Period _____

Were there any complications at birth? Yes ☐ No ☐ If yes, please describe

_____

_____

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

Are your child's immunizations up to date? Yes ☐ No ☐

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

_____

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

_____

_____

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: _____

Has your child had any serious illnesses, accidents or hospitalizations? Please list

_____

_____

OTHER SUPPORT SERVICES

Is your child receiving services from any other individuals or programs? Check all that apply and name of service provider

☐ Infant Development Program _____
☐ Physiotherapy _____
☐ Occupational Therapy_____
☐ Visual Impaired Program_____
☐ Speech Language Therapy _____
☐ Supported Child Care/Development_____
☐Preschool/ Daycare/Daycare_____
☐ Other: (list) _____

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 Society.

_____ _____
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:_____ Today's Date_____/_____/_____
(month/ day / year)

Your Name: _____
(Please print)