BC FAMILY HEARING
resource society

35 years of making futures bright
Bright futures for Children

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

- O Infant Development Program _____
- O Physiotherapy _____
- O Occupational Therapy_____
- O Visual Impaired Program_____
- O Speech Language Therapy _____
- O Supported Child Care/Development_____
- O Preschool/ Daycare/Daycare_____
- O 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)