SANDCASTLE
CLINICAL & EDUCATIONAL SERVICES
LA HEARING CENTER

THERAPY PERMISSION FORM

Client name:_______________________________________ Date of birth: __________________________

Please read and initial each item. Thank you.

_____ I give permission for Sandcastle to enroll my child in a therapy program.

_____ I understand that I must notify Sandcastle prior to the appointment time if my child is unable to attend a scheduled therapy session.

_____ I understand that under special circumstances make up sessions may be arranged for missed therapy sessions. However, this arrangement is not always possible due to scheduling commitments.

_____ I am aware that observations or participation in therapy session is supported and encouraged.

_____ I give permission for individuals involved in my child's program to observe my child's therapy session.

_____ I give permission for my child to be seen by an alternate provider in the event that the regular treating provider is absent.

_____ I understand that if my child has excessive absences I will be notified about the discharge of my child from therapy.

_______________________________________ ______________________________

Signature of Parent or Guardian Date

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ADULT AUDIOLOGY CASE HISTORY

NAME: ______________________________ DOB: ____________ TODAY'S DATE: ____________

Reason for Referral: ______________________________ Problem First Noted: ____________

Please check all that apply to your hearing:

- ☐ Sudden change
- ☐ Decline in the last 6 months
- ☐ Fluctuations
- ☐ Other
- ☐ Gradual change
- ☐ Decline in the last 1 year
- ☐ Difference between ears

Please Explain: ______________________________

Have you been seen elsewhere for the problem? ☐ Yes ☐ No

If yes, where, when and what was found/suggested? ______________________________

What do you think caused the problem? ______________________________

What difficulties have you experienced related to the problem? ______________________________

Have you ever been exposed to occupational or recreational noise? (Ex: music, gun fire, machinery, power tools)

☐ Yes ☐ No Examples: ______________________________

If yes, have you used hearing protection devices (i.e. earplugs, earmuffs): ☐ Yes ☐ No

Hearing Aid History

Have you ever worn a hearing aid(s)? ☐ Yes ☐ No Do you use a hearing aid(s) now? ☐ Yes ☐ No

If yes, how long have you had a hearing aid? ______________________________

MEDICAL HISTORY:

Have you ever had surgery to your head, neck or ears? ☐ Yes ☐ No Explain: ____________

Have you ever been admitted to the hospital for serious illness or injury? ☐ Yes ☐ No

If yes, please explain: ______________________________

To your knowledge, have you ever been exposed to ototoxic medication (i.e. chemotherapy, radiation, lifesaving antibiotics)? ☐ Yes ☐ No Explain: ______________________________

Is there any family history of hearing loss or deafness? ☐ Yes ☐ No Explain: ____________

Do you have, or have you had (*please check all that apply*):

- ☐ Ear Pain
- ☐ Ear infection
- ☐ Draining Ears
- ☐ Aural Fullness
- ☐ Excessive Earwax
- ☐ Allergies
- ☐ Sinusitis
- ☐ Frequent Colds
- ☐ Tinnitus (ringing, roaring, sounds in ears)
- ☐ Vertigo/dizziness/off balance
- ☐ Illness with high fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Facial Numbness
- ☐ Blurred Vision
- ☐ Heart Disease
- ☐ Convulsions
- ☐ Stroke
- ☐ Seizure
- ☐ Cancer

Other: ______________________________

Please provide a copy of all medications, including: prescriptions, over the counter, herbal supplements & vitamins (or provide list on a separate page).