College of Health and Behavioral Studies

Communication Sciences and Disorders
JMU Audiology Clinic
235 Martin Luther King Jr. Way, MSC 4304
Harrisonburg, VA 22807
Telephone: 540-568-6491
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Infant Screening Intake Form

The information you provide will enable us to have a better understanding of your concerns and will expedite the process of the speech/hearing evaluation. All material and information is kept in strict confidence.

Date | License Plate # and State (for parking pass)

Patient Name | Date of Birth | Age | Gender

Primary Contact: Name | Relationship to Child | Phone | Email

May we leave a message at the phone number listed above? Yes ☐ No ☐

Mother's Name | Age | Father's Name | Age

Home Address

Mother's Occupation | Place of Employment | Work Phone | Cell Phone

Father's Occupation | Place of Employment | Work Phone | Cell Phone

Family Doctor/Pediatrician/Medical Clinic | Phone | Address

Is there a family history of hearing loss that began at birth or during childhood? Yes☐ No☐ Unknown☐

If yes, please list the relationship of affected family member(s): (i.e. brother, aunt, etc.) _____

Do you have a concern regarding the hearing of the infant being tested? Yes ☐ No ☐ Not Sure ☐

If yes, please describe your concerns: _____

_____

Birth History

Where was your child born? (List type and name of the facility)_____

Did your child have a newborn hearing screening at birth? Yes ☐ No ☐ Results: Pass ☐ Fail ☐

Pregnancy (Prenatal):

Were there any complications during pregnancy (prenatal)? Yes ☐ No ☐ Unknown ☐

If yes, please describe complications during pregnancy (i.e. accidents, illness, medications or x-ray treatment):

_____

_____

Was the mother exposed to any infectious diseases during pregnancy? Yes ☐ No ☐ Unknown ☐

If yes, please describe: _____

Was tobacco, alcohol, medication or another substance used during pregnancy? Yes ☐ No ☐ Unknown ☐

If yes, please describe: _____

Birth (Perinatal):

Gestational Age (weeks old at birth): _____ Birth Weight: _____

Delivered: ☐ Vaginal ☐ Caesarean ☐ Breach ☐ Jaundiced ☐ Other: _____

Instruments Used: _____ Length of Labor: _____

After Birth (Postnatal):

APGAR scores: _____

Was the infant hospitalized for longer than 48 hours after birth? Yes ☐ No ☐ Unknown ☐

Was the infant placed in the NICU or a special unit? Yes ☐ No ☐ Unknown ☐

If yes, where and for how long? _____

Did your child receive antibiotics immediately after birth or during their hospital stay? Yes ☐ No ☐ Unknown ☐

Did your child need mechanical ventilation (breathing machine) or oxygen after birth? Yes ☐ No ☐ Unknown ☐

If yes, for how long? _____

Please describe any other complications during pregnancy, during birth or after birth: _____

_____

Parent/Legal Guardian Signature: ____ Date: ________________