INITIAL DEMOGRAPHIC FORM

GENERAL INFORMATION Today's date: ☐

Child's name: ☐

Names of adults in the home: ☐

City: ☐ State: ☐ Zip Code: ☐

Birthdate of child: ☐ Sex of child: ☐ Boy ☐ Girl

1. Family qualifies for WIC and/or SNAP (food/nutrition assistance program):

☐ yes ☐ no ☐ unknown

2. Ethnicity of child: ☐ Hispanic/Latino/Spanish ☐ NOT Hispanic/Latino/Spanish

3. Race of child (check all that apply):

☐ White ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ American Indian or Alaska Native

☐ Asian ☐ Other (describe): ☐

4. Languages used at home with the child (please check <u>all</u> that apply):

☐ Spoken English ☐ Spanish

☐ Sign Language ☐ Other (describe): ☐

HEARING INFORMATION

1. Newborn hearing screening results: ☐ did NOT pass in one or both ears

☐ passed in both ears ☐ did not receive ☐ results unknown

2. Onset of hearing loss: ☐ Present at birth ☐ Acquired after birth ☐ Don't know

If acquired, at what age? ☐ months of age

3. Age hearing loss was confirmed by an audiologist: ☐ months of age

4. Age first received hearing technology: ☐ months of age

5. Age intervention associated with communication first started: ☐ months of age

6. Cause of hearing loss:

- ☐ ***Unknown***
- ☐ Atresia
- ☐ CHARGE
- ☐ Cleft palate
- ☐ CMV (Cytomegalovirus)
- ☐ Cochlear dysplasia
- ☐ Cornelia de Lange syndrome
- ☐ Down syndrome
- ☐ Auditory nerve absent/insufficiency
- ☐ Stickler syndrome and/or Pierre Robin sequence
- ☐ EVA (Enlarged Vestibular Aqueduct)
- ☐ Genetic/hereditary
- ☐ Goldenhar syndrome
- ☐ Meningitis
- ☐ Ototoxicity
- ☐ Pendred syndrome
- ☐ Treacher Collins syndrome
- ☐ Usher syndrome
- ☐ Other (describe): ☐

7. *Current* hearing technology owned or on loan (even if not currently used):

- ☐ None
- ☐ FM/DM system
- ☐ Bone conduction device (BAHA or similar)
- ☐ Hearing aid(s)
- ☐ Cochlear implant*

*If the child has a cochlear implant...

First CI -- Date implanted: ☐ Date activated: ☐

Second CI -- Date implanted: ☐ Date activated: ☐

8. Current hearing technology use:

- ☐ None – has/had hearing technology but doesn't use
- ☐ N/A – never had hearing technology
- ☐ 1-3 hrs/day ☐ 4-5 hrs/day ☐ 6-8 hrs/day ☐ > 8 hrs/day

FAMILY INFORMATION

1. Is there a deaf or hard-of-hearing adult in the home? ☐ yes ☐ no
   -- If yes, does that person use sign language? ☐ yes ☐ no ☐ N/A

2. In the table:
   a) list the adult(s) living with the child by their relationship to the child (e.g., mother)
   b) include each adult's date of birth,
   c) check the **highest** degree *completed* by each person

	Adult 1: ☐ **Date of birth:** ☐	**Adult 2**: ☐ **Date of birth:** ☐
Did not complete HS	Last grade **completed**: ☐	Last grade **completed**: ☐
High School Diploma	☐	☐
Vocational Degree	☐	☐
Associate Degree	☐	☐
Bachelor's Degree	☐	☐
Master's Degree	☐	☐
J.D. or Ed.D	☐	☐
M.D.	☐	☐
Ph.D.	☐	☐

3. Mode of communication ***currently used by adults*** in the home ***with*** the child:

☐ spoken language only ☐ spoken language with occasional signs

☐ speech + sign ☐ sign only (no spoken language) ☐ Cued Speech

☐ Augmentative/Alternative Communication (AAC) system(s): ☐

4. Mode of communication ***currently used by the child***:

☐ none yet ☐ spoken language only ☐ spoken language with occasional signs

☐ speech + sign ☐ sign only (no spoken language) ☐ Cued Speech

☐ Augmentative/Alternative Communication (AAC) system(s): ☐

ADDITIONAL DISABILITIES

Please check issues that are formally diagnosed and/or suspected:

- ☐ ***No other disabilities***
- ☐ Brain injury
- ☐ Cerebral palsy (CP)
- ☐ Cognitive delay
- ☐ Autism Spectrum Disorder
- ☐ Balance disorder
- ☐ Significant medical issues
- ☐ Other disability (please explain): _____
- ☐ Vision impairment or blind
- ☐ Seizures/Epilepsy
- ☐ Emotional
- ☐ Motor
- ☐ Behavioral
- ☐ Cleft lip/palate
- ☐ Sensory/Motor processing/integration

Rate the effect of any disabilities the child has **(*other than hearing loss*)** on his/her speech/language development:

- ☐ 1 No disabilities other than hearing loss
- ☐ 2 One or more other disabilities, but they do not interfere with speech/language
- ☐ 3 One or more other disabilities that provide minimal obstacles to speech/language
- ☐ 4 One or more other disabilities that provide moderate obstacles to speech/language
- ☐ 5 One or more other disabilities that provide significant obstacles to speech/language

EDUCATION AND INTERVENTION

Child attends preschool/kindergarten (do NOT include daycare): ☐ Yes ☐ No

If yes, please complete the following:

Name of School: _____ Teacher's Name: _____

Type of School Setting	Sessions per month	Minutes per session
Preschool/kindergarten primarily for deaf/hard-of-hearing children		
Preschool/kindergarten for children with a variety of special needs		
Preschool/kindergarten primarily for hearing children		

In this table include services that the child/family **currently receives at least once a month**. Do not include services that happen while the child is in school. List each intervention **just ONCE** (wherever it fits best).

Type of Intervention	Typical delivery mode	Sessions per month	Minutes per session
Early intervention in the home associated with communication Interventionist's Name: ☐ Program/Agency's Name: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐
Early intervention (individual) outside the home associated with communication (e.g., in a clinic, hospital, private office) Interventionist's Name: ☐ Clinic/Facility's Name: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐
Speech or auditory therapy in the home Speech Therapist's Name: ☐ Program/Agency's Name: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐
Speech or auditory therapy (individual) outside the home Speech Therapist's Name: ☐ Clinic/Facility's Name: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐
Deaf/Hard-of-hearing adult provides mentoring and/or sign instruction Mentor/Instructor's Name: ☐ Program/Agency's Name: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐
Sign language class outside the home Teacher's Name: ☐ Program's Name: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐
Early intervention (toddler) group Interventionist/Teacher's Name: ☐ Facility/School's Name: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐
Occupational Therapy (OT)		☐	☐
Physical Therapy (PT)		☐	☐
Other - describe: ☐ Program/agency: ☐	☐ telehealth ☐ in person ☐ hybrid	☐	☐

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