Child's Hearing Questionnaire

Reception No.

Child's name （ ）
Child's date of birth (____year ___month ___day)
Your relationship to child （ ）

☆ Please read the following questions about your child and circle the applicable answer.

Questions	Answers	
① Have any of your child's family/relatives been hard of hearing since they were very young?	no	yes
② Has your child ever contracted otitis media (inflammation of the middle ear)?	no	yes
③ Does your child often have nasal congestion, nasal drip, breathe through their mouth, or dry throat?	no	yes
④ Have you ever wondered if your child is hard of hearing due to not responding when called, asking you to repeat yourself, or watching loud television?	no	yes
⑤ Has anyone in close contact with your child (daycare staff, etc) ever said that your child is hard of hearing?	no	yes
⑥ Have you ever had any concerns about your child's speech being slow, having odd pronunciation, etc?	no	yes
⑦ Do you ever need to supplement your speech with gestures in order to be understood?	no	yes

☆ Whisper Test Results

Say the name of the picture 1 time only. Even if they ask you to repeat yourself, please do not repeat the word. Draw a circle under the words they answer correctly, and an X under the words they ask you to repeat or answer incorrectly.

dog	shoes	umbrella	elephant	cat	chair