BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

COCHLEAR IMPLANT SERVICE PATIENT QUESTIONNAIRE

Patient's Name**:** ____________________ Date of birth**:** ____ /____ / _____
d m y

B.C. Children's Unit #: _______________________ Provincial Health #: ________________________________

Address: ____ Gender: ☐ Male
____ ☐ Female

Date Questionnaire completed: ____________________

Primary Parent Contact Phone#: ____________________

Email: ________________________________

Email: ________________________________

Has your child been a patient at B.C. Children's Hospital? Yes ___ No ___

BACKGROUND INFORMATION

Form Completed by: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other __________________

Child is presently living with:

☐ Biological Mother	☐ Stepmother	☐ Maternal Grandmother	☐ Mother's Partner
☐ Biological Father	☐ Stepfather	☐ Maternal Grandfather	☐ Father's Partner
☐ Adoptive Mother	☐ Foster Mother	☐ Paternal Grandmother	☐ Other
☐ Adoptive Father	☐ Foster Father	☐ Paternal Grandfather	☐ Other

Mother' (s) Name: _________________ Father' (s) Name: ________________

Marital Status of Parents: ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Re-married

If separated or divorced, how old was the child when the separation occurred? _________________

Who has custody of the child? ________________ Type of Custody? ☐ Sole ☐ Joint

If not living in the same home, how often does the other parent see this child? _________________

If remarried, how old was the child when the stepparent entered the family? _________________

Name of Legal Guardian(s) (if different from above): _____________________________________

Language(s) spoken at home: _____________________________________

Brothers and sisters of the patient:

Name	Age	Sex	Hearing, developmental or health problems
____________________	_______	_______	_____________________________________
____________________	_______	_______	_____________________________________
____________________	_______	_______	_____________________________________
____________________	_______	_______	_____________________________________

Have they had a hearing test? Yes ____ No ___

Is the **father** or any of his family hard-of-hearing since childhood? Yes ___ No___

If yes, who? ______________________ When was the loss discovered? ______________

Is a hearing aid used? _______________ If yes, from what age?________________

Is the **mother** or any of her family hard-of-hearing since childhood? Yes ___ No___

If yes, who? ______________________ When was the loss discovered? ______________

Is a hearing aid used? __________________ If yes, from what age? ____________________

AUDIOLOGICAL INFORMATION

1) Is your child's hearing loss considered, overall, to be:

Mild __Moderate ___ Severe ___ Profound ___

2) Was the hearing loss from birth? Yes ___ No ___ (If Yes, proceed to #5)

3) Was your child able to talk before he/she lost his/her hearing? ____________

4) Approximate date of onset of hearing loss: right ear ______ left ear ______

5) Was the loss progressive? (Has it become worse over time?) Yes ___ No ___

6) Is the hearing the same in both ears? Yes ___ No ___

If No, which ear is worse? Right ___ Left ___

7) Cause of hearing loss (if known):_______________________________________

8) Date of hearing loss diagnosis: ______________________________

9) Where was the hearing loss diagnosed: ______________________

10) Is your child currently part of the province's Early Hearing Program?

Yes ____ No ___

HEARING AIDS

1) Does your child wear hearing aids? Yes ___ No ___

2) Date hearing aids were fit: ________________

3) How many hours a day does your child wear the hearing aids? ____________

4) Name and Model of the hearing aid (s):

   Ear: Right ___________________ Left __________________

5) Does your child use an FM system at home? Yes ___ No ___
   How about at school/preschool? Yes ___ No ___

SPEECH AND LANGUAGE

1. Primary mode of communication (e.g., speech, sign language, total communication, gestures
   ____
2. Approximately how many **words** does your child **understand** now?
   ____
3. Approximately how many **words** does your child **say** now?
   ____
4. Approximately how many **signs** does your child **understand** now?
   ____
5. Approximately how many **signs** does your child **use** now?
   ____

DEVELOPMENTAL MILESTONES

At what age did your child do the following? Please indicate year/month of age.

Milestone	Age	Milestone	Age
Smiled		Bladder trained (Day)	
Sat with no support		Bladder trained (Night)	
Crawled		Bowel trained	
Walked with no assistance		Rode bicycle (with training wheels)	
Spoke first words		Rode bicycle (without training wheels)	
Spoke using two word sentences		Dressed self unassisted	
Fed self with spoon		Buttoned clothing	
Said alphabet		Tied own shoelaces	
Began to read		Named coins	

Has your child been referred for a developmental assessment? Yes ___ No ___

If **YES** When: __________________ Where: _________________________

EDUCATION HISTORY

PRESCHOOL

1) Is (Was) your child enrolled in a habilitation program? Yes ___ No ___

2) Name of the program: ________________________

3) Start Date: ________________ Ending Date: ________________

4) Name of primary Habilitationist: ________________

5) Communication Mode: __________________________________

6) Is your child involved with any other programs (i.e. daycare, nursery, individualized therapy)
____

SCHOOL PROGRAM(S)

Please include all schools your child has attended and list the types of classes he/she has been enrolled in (i.e. a self-contained class of a small number of children with hearing loss, classes with normally hearing children, etc.) Please continue on back of page if necessary.

Name of School**:** _____________________________ Grade(s): ________________________

Name of School Board: ________________________ Class Type: ________________________

Teacher(s): __________________________________

Hearing Resource Teacher: __________________________________

Communication Mode: ____

Starting Date: ________________________ Ending Date: ________________________

Name of School**:** _____________________________ Grade(s): ________________________

Name of School Board: ________________________ Class Type: ________________________

Teacher(s): __________________________________

Hearing Resource Teacher: __________________________________

Communication Mode: ____

Starting Date: ________________________ Ending Date: ________________________

1) Does your child use an FM system at school? Yes_____ No _____

2) Does your child attend any classes with children that have normal hearing?

Yes_____ No _____ If Yes which classes? ________________________

3) Has your child exhibited any learning problems? Yes _____ No _____
If Yes, what kinds? ____

4) Please list all type of services your child receives at school or outside of school (eg. OT, PT)
____
____

5) Has your child ever had or been referred for a **psycho-educational/developmental** assessment?
Yes ___ No _____ (**If one has been done, please provide a copy of the report**)

Name of Psychologist: ____________________________________

BIRTH HISTORY

1) Premature Birth? Yes_____ No _____

Duration of pregnancy in weeks ____________________

Weight of child at birth? ______________________

2) Were there any illnesses or complications during pregnancy? Yes ___ No___

If yes, please describe ____

3) Was labour normal? Yes ______ No _______

If no, please describe ____

4) Type of delivery (ex: vaginal, C-section) ____

5) Has your child spent time in the special care nursery? Yes ____ No ______

If yes, how long? _____________________________________

6) Was your child yellow or jaundiced after birth? Yes___ No _______

7) Did your child receive a blood transfusion? Yes ___ No _______

8) Has your child ever had Streptomycin, Neomycin, Kanamycin, Gentamycin or a similar antibiotic?

Yes___ No _____

If yes, at what age, for what and for how long?____

9) Has your child ever had a **CT scan** of his/her inner ear or cochlea?

Yes ___ No _____

If yes, please indicate **date** and **place** it was done: ____

10) Has your child ever had a **MRI scan** of his/her inner ear or cochlea?

Yes ___ No ______

If yes, please indicate **date** and **place** it was done: ____

11) Has your child been immunized for meningitis? Yes ________ No ________

12) Has your child's vision been tested? Yes ________ No ________

If **YES**, please indicate **date** and **place** it was done: ____

Name of Ophthalmologist: ____

TEMPERAMENT

How active is your child? ☐ Very Active ☐ Average ☐ Inactive

How well does your child play well with other children? Very Well ☐ Average ☐ Poor

What is your child's basic mood? Happy ☐ Angry ☐ Anxious/Scared ☐ Sad

Are you able to effectively manage your child's behaviour at home? ☐ Yes ☐ No

Is your child's behaviour easily managed in the school setting? ☐ Yes ☐ No ☐ Not Applicable

Other:

Besides the hearing loss, does your child exhibit other difficulties? Briefly describe any concerns you might have about your child, and any ideas you may have about the cause of these problems:

____

____

____

Has your child had any social, emotional, behavioural, or learning problems in the past?

____

____

FAMILY HISTORY

Number of household moves in the child's lifetime? ______________

How long has the child been at the current address? ______________

If your child is adopted, at what age was he/she adopted? ______________

Describe any relevant information you have about the biological parents (e.g., medical history, developmental difficulties, etc.) ____

____

Have any family members experienced any of the following conditions? If yes, please identify the family member's relationship to your child (e.g., brother, mother, maternal grandparent, uncle, etc.)

- □ Anxiety
- □ Depression
- □ Aggression, Neurological (e.g., epilepsy)
- □ Genetic Disorder
- □ Autism
- □ Learning Problems
- □ Attention Problems
- □ Hyperactivity/Distractibility
- □ Developmental Delays
- □ Speech or Language Problems

All families experience stress. Please indicate if the following have occurred in your family:

- □ Parental divorce
- □ Parental separation
- □ Parent remarried
- □ Parent lost job
- □ Excessive conflict
- □ Death of a parent
- □ Death of a sibling
- □ Death of a grandparent
- □ Significant illness/injury
- □ Child physical abuse
- □ Child sexual abuse
- □ Move to another home
- □ Change of schools
- □ Peer difficulties
- □ Child's pet died
- □ Other ________________
- □ Other ________________

PROFESSIONAL INVOLVMENT

Please list contact information for health professionals (e.g., psychologist, speech-language pathologist, pediatrician, medical specialist, mental health professional, physical therapy, occupational therapist) who have previously conducted assessments and/or services to your child. If known, please provide phone number and address.

Name	Profession	Agency (phone # & Address)

Thank You for Completing This Questionnaire!

****PLEASE ENCLOSE COPIES OF ALL AVAILABLE AUDIOGRAMS AND OTHER RELEVANT REPORTS****

Please return the complete questionnaire (including copies of ALL available audiograms and other relevant reports) to:

B.C. Children's Hospital
4480 Oak Street
Cochlear Implant Services
Room 1D-20
Vancouver, British Columbia, Canada V6H 3V4
Phone (604) 875-2345 ext. 7723 Fax: (604) 875-2977