Early Development of Children with Hearing Loss

Please answer each question as completely as possible. There is a good reason for each question. If you would like further explanation for a specific question, please call us at (800) 678-6254. All information is kept strictly confidential. That means that we will not tell anyone that you have offered to participate in this study, unless we check with you first. We will not share with anyone, other than you, any personally identifiable information obtained in any part of this study, including from this questionnaire.

Contact Information

Child's Full Name: ____ Sex: ☐M ☐F Today's date: _____/_____/_______

Child's date of birth: ______/_______/________ City and state of child's birth:____

Parent(s)' Name(s): ____

Street address:____ City, State, Zip: ____

Home Phone: (_______)________________ Work Phone: (_______)______________ Cell Phone: (_______)__________________

Which number is best to reach you? ☐ Home ☐ Work ☐ Cell What time of day? ☐Mornings ☐Afternoons ☐Evenings

Email address: ____

General and Family History

1) What are the genders and birth dates of other children in the family?

Gender	Birth date
__________	______________________________
__________	______________________________
__________	______________________________

(If more room is needed please use the back)

2) Has your child been generally healthy since birth?

☐YES ☐NO

If NO, please explain briefly. _________________________

____

____

3) Was your child a full-term birth?

☐YES ☐NO

If NO, at how many weeks was your child born? _________

4) Has a health professional ever expressed concern that your child may have a health problem or disability other than hearing loss? ☐YES ☐NO

If YES, what is the nature of the other problem? ___________

____

____

5) Do any other family members have a speech, language, or hearing problem? ☐YES ☐NO

If YES, please explain briefly. _________________________

____

6) Are any languages *other than English* spoken in the home (including Sign Language and *Baby Sign*)? ☐YES ☐NO

If YES, what language(s)? _________________________

What proportion of the time are they spoken?

☐5% ☐25% ☐50% ☐75% ☐100%

7) What is your family's total gross income each year? *Please mark one.*

☐ Less than $20,000 ☐ Between $20,000 and $30,000 ☐ Between $30,000 and $45,000 ☐ More than $45,000

7a) What is the Father's Primary Occupation?

____

7b) What is the Mother's Primary Occupation?

____

8a) What is the Father's highest level of education?

- ☐ Completed elementary school only
- ☐ Completed junior high school only
- ☐ Earned Graduate Equivalence Degree (GED)
- ☐ Graduated from High School
- ☐ Attended 1+ years of technical/vocational school
- ☐ Graduated from technical/vocational school
- ☐ Attended 1+ years at a university/college
- ☐ Bachelor's degree
- ☐ Attended 1+ years of graduate school
- ☐ Master's degree
- ☐ Ph.D. (ABD); J.D. before Bar admission; M.D., pre-internship
- ☐ Ph.D.; J.D. with Bar admission; M.D., internship completed

8b) What is the Mother's highest level of education?

- ☐ Completed elementary school only
- ☐ Completed junior high school only
- ☐ Earned Graduate Equivalence Degree (GED)
- ☐ Graduated from High School
- ☐ Attended 1+ years of technical/vocational school
- ☐ Graduated from technical/vocational school
- ☐ Attended 1+ years at a university/college
- ☐ Bachelor's degree
- ☐ Attended 1+ years of graduate school
- ☐ Master's degree
- ☐ Ph.D. (ABD); J.D. before Bar admission; M.D., pre-internship
- ☐ Ph.D.; J.D. with Bar admission; M.D., internship completed

Please complete second page

Hearing and Intervention Information

9) What age was hearing loss first suspected? _______________

10) What age was hearing loss diagnosed for certain? __________

11) Is hearing loss in both ears? ☐ YES ☐ NO

If YES, which ear has **better hearing** than the other?

☐ Left ☐ Right ☐ Both have equal amount of hearing loss

12) Can you describe the severity of the hearing loss in each ear?

LEFT: _____dB and ☐Moderate ☐Severe ☐Profound

RIGHT: _____dB and ☐Moderate ☐Severe ☐Profound

13) What does your child **currently** use for amplification (Please check the appropriate ear(s)?

☐ Hearing Aids ☐ Left Age Received _______
☐ Right Age Received _______

☐ Cochlear Implant ☐ Left Age Received _______
☐ Right Age Received _______

14) Did your child use a different amplification system before their current one? ☐ YES ☐ NO

If YES, what did your child use?

☐ Hearing Aids ☐ Left Age Received _______
☐ Right Age Received _______

☐ Cochlear Implant ☐ Left Age Received _______
☐ Right Age Received _______

15) Does your child use an FM system? ☐YES ☐NO

16) Does your child wear his/her hearing aids or cochlear implant during all waking hours? ☐ YES ☐ NO

If NO, when does he/she wear them? ____________________

17) How many middle ear infections has your child had? ______

18) Does (did) he/she have ventilation tubes? ☐YES ☐NO
When were they implanted-removed? ___________________

19) Other than surgery to place ventilation tubes or cochlear implant, has your child ever had ear surgery? ☐YES ☐NO

If YES, what kind?____________________________________

20) What type of setting do you imagine your child in ten years from now?

- ☐ Regular class speaking and understanding others on his/her own without sign language
- ☐ Regular class with a sign-language interpreter
- ☐ Program that uses sign language
- ☐ Unsure

21) Who is your child's audiologist?

Name of Audiologist ______________________________

Institution ____________________________________

Address ______________________________________

____

Phone (________)______________________________

PRIMARY SERVICE PROVIDER

22) From where do (did) you and your child receive intervention services?

Name ____

Address ____

____

Phone (________)_______________________________

a. When did you and your child start using this intervention? ____/_____/____

b. Please indicate the type of intervention service:

☐ Auditory-Oral
☐ Sign-Supported
☐ Auditory Verbal

c. Does someone come to your home or do you go to a center?

☐ Home ☐ Center ☐ Both

d. When you and your child meet with your service provider, do they spend more time working with you or with your child?

☐ You ☐ Your Child ☐ Both equally

e. How many times each month does your child spend with this service provider? __________

SECONDARY SERVICE PROVIDER

23) Secondary Service Provider (if applicable):
(If more room is needed please use the back)

Name ____

Address ____

____

Phone (________)_______________________________

a. When did you and your child start using this intervention? ____/_____/____

b. Please indicate the type of intervention service:

☐ Auditory-Oral
☐ Sign-Supported
☐ Auditory Verbal

c. Does someone come to your home or do you go to a center?

☐ Home ☐ Center ☐ Both

d. When you and your child meet with your service provider, do they spend more time working with you or with your child?

☐ You ☐ Your Child ☐ Both equally

e. How many times each month does your child spend with this service provider? __________

24) From where did you receive the first brochure about this research project?_______________________________

25) What days and times would be best for you and your child to participate in this project? ______________________

I would like to be contacted about having my child participate in this study.

Parent Signature:_______________________________________ **Date:**________________

Please send this questionnaire to: EDCHL Study, 37 Pressey Hall, 1070 Carmack Road, Columbus, OH 43210