Central Auditory Processing Disorder (CAPD) Questionnaire for Adults

Name: __________________________ Date: _________________

The purpose of this questionnaire is to identify problems you are having that might be a result of CAPD. Please complete all sections.

Section 1: Have you ever been diagnosed with any of the following? Check all that apply and provide details in the spaces provided.

☐ Alzheimer’s or other dementia ______________________________

☐ Anxiety disorder ______________________________

☐ Attention deficit hyperactivity disorder (ADHD / ADD) ______________________________

☐ Auditory hallucinations ______________________________

☐ Autism, Asperger or other spectrum disorder ______________________________

☐ Bipolar disorder ______________________________

☐ Chronic ear infections (left ear / right ear) ______________________________

☐ Depression ______________________________

☐ Down’s syndrome ______________________________

☐ Dyslexia ______________________________

☐ Exposure to toxic chemicals or fumes ______________________________

☐ Head or neck trauma / injury ______________________________

☐ Hearing loss ______________________________

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☐ Human immunodeficiency virus (HIV / AIDS) ________________________________

☐ Huntington’s disease ________________________________

☐ Hyperacusis ________________________________

☐ Hypoxia / anoxia ________________________________

☐ Lead poisoning ________________________________

☐ Learning disability (LD) ________________________________

☐ Lupus ________________________________

☐ Lyme disease ________________________________

☐ Memory loss ________________________________

☐ Migraine ________________________________

☐ Multiple sclerosis ________________________________

☐ Parkinson’s disease ________________________________

☐ Rubella or other childhood virus ________________________________

☐ Schizophrenia ________________________________

☐ Shingles ________________________________

☐ Williams syndrome ________________________________

☐ Other neurologic, cognitive, or sleep disorder ________________________________

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Section 2: Check all symptoms that you have had within the last year and provide details in the spaces provided.

☐ Hearing loss (left ear / right ear) ________________________________

☐ Difficulty hearing when there is background noise or reverberation __________

☐ Difficulty hearing on the telephone (left ear / right ear) _______________________

☐ Sensitivity to loud and/or sudden noises _________________________________

☐ Difficulty comprehending rapid speech _________________________________

☐ Tinnitus (left ear / right ear) _________________________________

☐ Dizziness, imbalance or vertigo _________________________________

☐ Numbness or tingling in the face _________________________________

☐ Difficulty following long conversations _________________________________

☐ Difficulty learning a foreign language or vocabulary words _________________

☐ Difficulty remembering spoken information _________________________________

☐ Difficulty taking notes _________________________________

☐ Difficulty maintaining focus on an activity if other sounds are present __________

☐ Poor organizational skills _________________________________

☐ Forgetful _________________________________

☐ Difficulty following multi-step directions or repeating numbers in sequence ________
Difficulties in direction, sustaining or dividing attention

Difficulty with reading and/or spelling

Difficulty comprehending abstract or complex information

Difficulty interpreting or recalling non-verbal environmental sounds or music

Talk louder than necessary

Interpret words too literally

Difficulty expressing clearly using speech

Ignore a speaker especially if preoccupied by something

Other

Section 3: List your current medications and dosages, and indicate when you last took each one.

Section 4: What is your primary symptom or difficulty today?