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AUDITORY CHECK LIST

Student Name		Age	Birthdate	
Today's Date	Grade		Observer	
Please place a checkmark before	each item that is co	onsidered to	be a concern by the o	bserver.
1. Has a history of hearing lo	OSS.			
2. Has a history of ear infect	tion(s).			
3. Has history of Migraine?	Seizure? Head Inju	ry/concussio	on?	
4. Has history of Visual Pro	cessing Evaluation/	Therapy?		
5. Does not pay attention (lis	sten) to instructions	50% or mor	e of the time.	
6. Does not listen carefully t	o directions – often	necessary to	repeat instructions.	
7. Says "huh?" and "what?"	at least five or mor	e times per d	lay.	
8 Can not pay attention to au	uditory stimuli (hear	ring activity)) for more than a few	seconds.
9. Has a short attention span	(If this item is chec	cked, also ch	eck the most appropr	riate time frame.)
0-2 minutes 5-15 minutes	2-5 m 15-30	inutes minutes		
10. Daydreams - attention da	rifts - not "with it" a	nt times.		
11. Is easily distracted by ba	ckground sound(s).			

12. Has difficulty with phonics.
13. Has difficulty rhyming.
13. Has difficulty singing.
15. Experiences problems with sound discrimination.
16. Forgets what is said in a few minutes.
17.Does not remember simple routine things from day to day.
18. Displays problems recalling what was heard last week, month, year.
19. Has difficulty recalling a sequence that has been heard.
20. Experiences difficulty following auditory directions (directions child hears).
21. Frequently misunderstands what is said.
22. Does not understand many words for particular age and/or grade level.
23. Learns poorly when only listening to the information.
24. Has a language problem (structure of words and sentences, vocabulary, sounds or articulation)
25. Has an articulation problem.
26. Cannot always relate what is heard to what is seen.
27. Lacks motivation to learn.
28. Displays slow or delayed response to verbal stimuli.
29. Demonstrates below average performance in one or more academic areas.

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