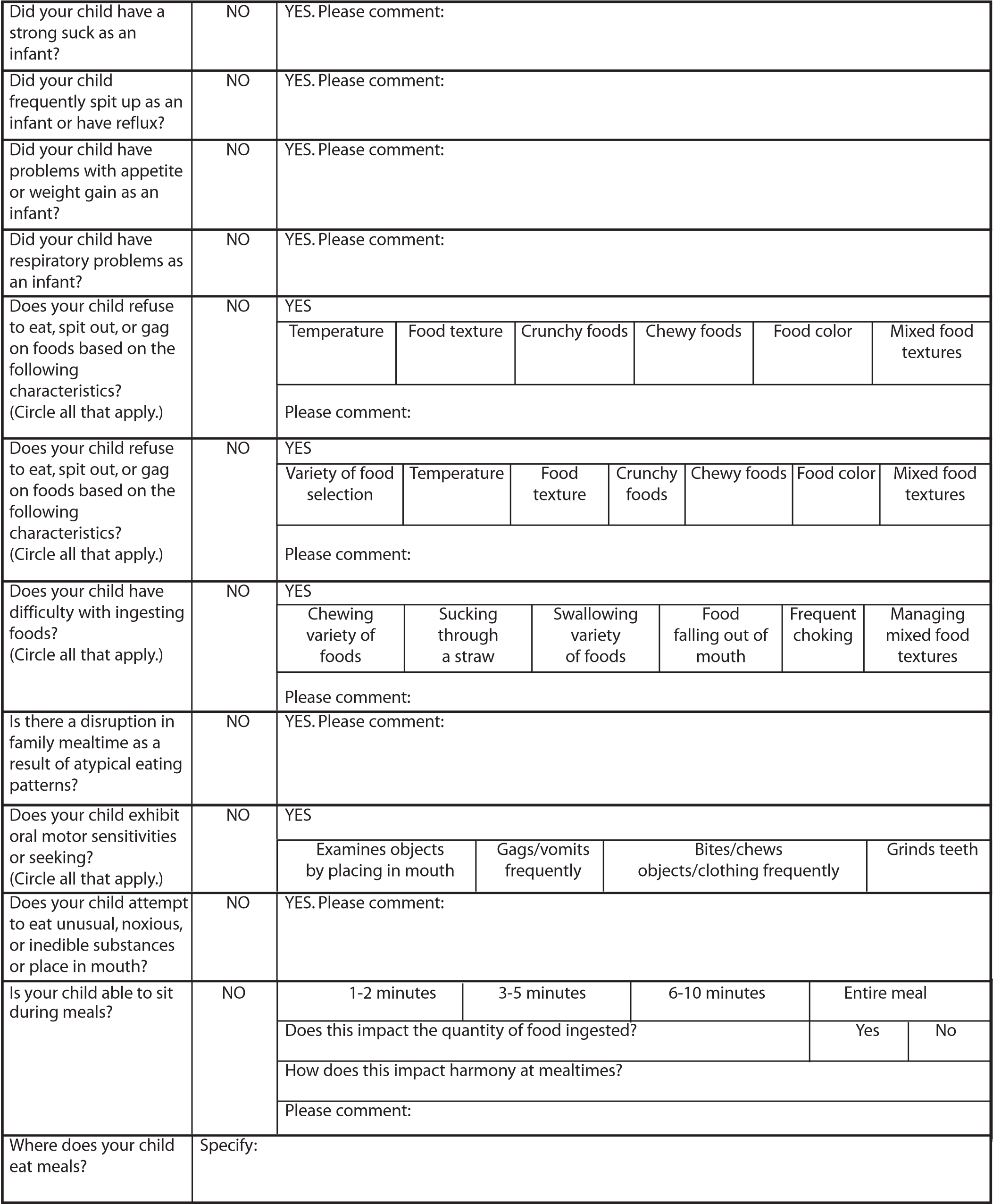
**Functional Listening Questionnaire**

Date:

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| **CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Child’s Name | | | | | | | | Sex | | | Date of Birth | | | | | | | | Age | |
| Parent(s) Name(s) | | | | | | | | | | | | | | | | | | | | |
| Address | | | | | | | | | | | | | | | | | | | | |
| City | | | | | State | | | | | | Zip Code | | | | | | | | | |
| Email | | | | | | | | | | | | | | | | | | | | |
| Phone # | Home | | | | | Work | | | | | | | | Cell | | | | | | |
| School Attending | | | | | | | | | | | | | | | | Grade/Level | | | | |
| Teacher’s Name | | | | | | | | | | | | School Phone # | | | | | | | | |
| **GENERAL INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Were there any  complications, illnesses, or stress during pregnancy? | | NO | YES. Please specify: | | | | | | | | | | | | | | | | | |
| Were there any complications during labor or delivery? | | NO | YES. Please specify: | | | | | | | | | | | | | | | | | |
| What is your child’s birth order? | |  | | | | | | | | | | | | | | | | | | |
| Please specify the conditions of your child’s birth. (Circle all that apply.) | | Vaginal | | Forceps | | | Vacuum | C-section | | | | | Premature | | | | Postmature | | | Full-term |
| What was your child’s birth weight? | |  | | | | | | | | | | | | | | | | | | |
| What were your child’s Apgar scores? | | At 1 minute: | | | | | | | | At 5 minutes: | | | | | | | | | | |
| Please indicate age/sex of any siblings. | |  | | | | | | | | | | | | | | | | | | |
| Has your child received Occupational Therapy services in the past? | | NO | YES | | | | | | | | | | | | | | | | | |
| At what age did your child begin therapy? | | | | | | | | | | | | | | | | | |
| How long did/has your child receive(d) therapy? | | | | | | | | | | | | | | | | | |
| How frequently was/is your child seen for therapy? | | | | | | | | | | | | | | | | | |
| Has/Does your child receive other interventions? (Circle all that apply.) | | NO | YES | | | | | | | | | | | | | | | | | |
| Speech Therapy | | | | Physical Therapy | | Applied Behavior  Analysis (ABA) | | | | | | DIR (Floortime) | | | Other(s): | | |
| How long? | | | | How long? | | How long? | | | | | | How long? | | | How long? | | |
| If the child has a medical diagnosis, please specify: | |  | | | | | | | | | | | | | | | | | | |

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| Does your child have a  history of ear infections? | NO | YES | | | | | |  | | | |
| How many? | | | | | |  | | | |
| At what ages? | | | | | |  | | | |
| Does your child currently take any medications? | NO | YES. Please specify: | | | | | |  | | | |
| Does your child have any allergies? | NO | YES. Please specify: | | | | | |  | | | |
| Has your child experienced any major injuries or hospitalizations? | NO | YES. Please specify: | | | | | |  | | | |
| Does your child wear glasses? | NO | YES | | | | | |  | | | |
| Does your child have a history of seizures? | NO | YES. Please comment: | | | | | |  | | | |
| Please note the approximate age when your child achieved the following skills. | Sitting | | Belly crawling | Crawling | | Cruising | Walking |  | First Words | | Talking |
| Hopping | | Jumping | Skipping | | Running | Riding a  tricycle |  | Riding a 2wheel bike | | Jump rope |
| What are your primary concerns? | Please comment: | | | | | | |  | | | |
| What is/are the hardest time(s) of day? | Please comment: | | | | | | |  | | | |
| Describe the impact on the child and other family members. | Please comment: | | | | | | |  | | | |
|  |  | | | | | | |  | | | |
| **SLEEPING** | | | | | | | |  | | | |
| What time does your child awaken? |  | | | | | | |  | | | |
| What mood is your child in upon morning waking? |  | | | | | | |  | | | |
| What time is your child put to bed? |  | | | | | | |  | | | |
| What time does your child fall asleep? |  | | | | | | |  | | | |
| Where does your child sleep? |  | | | | | | |  | | | |
| Does your child have difficulty with sleeping? | NO | YES | | | | | |  | | | |
| Falling asleep | | | Staying asleep | | | Frequent night waking | | | |
| Do family members have interrupted sleep as a result? | | | | | | Yes | | No | |
| How would you rate severity of sleeping issues? | | | | | | | | | |

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| How many times per night does he/she wake? | Almost never | | | | 1-2 | | | | 3-4 | | | 5-6 | | | | 7+ | |  |
| What does your child do when he/she awakens? | Whimper | | | Screams | | | Plays with toys | | | | Goes to parents’ bedroom | | | Puts self back to sleep | | |  | Other(s) |
| What activities do you use to get your child  back to sleep?  (Circle all that apply.) | Feeding | | Singing | | | Humming | | Holding | |  | Rocking | | Bouncing | | Massage | | | Other(s) |
|  |
| Describe your routines that are helpful for getting your child back to sleep. |  | | | | | | | | | | | | | | | | |  |
| How old was your child when he/she  consistently slept through the night? |  | | | | | | | | | |  | | | | | | |  |
| Does your child seem to require too much or too little sleep or at odd times? | NO | YES | | | | | | | | |  | | | | | | |  |
| How many hours nightly? | | | | | | | | |  | | | | | | |  |
| What times of day? | | | | | | | | |  | | | | | | |  |
| Does your child take naps? | NO | YES | | | | | | | | |  | | | | | | |  |
| Frequency of naps? | | | | | | | | |  | | | | | | |  |
| Duration of naps? | | | | | | | | |  | | | | | | |  |
| Locations of naps? | | | | | | | | |  | | | | | | |  |
| Does child need help to fall asleep for naps? | | | | | | | | |  | | | | | | |  |
| What activities do you use as part of your child’s bedtime routine? (Circle all that apply.) | Bath time | | Singing/  Humming | | | Reading | | Holding | |  | Bouncing | | Massage | | Rocking | | | Other(s) |
| Please describe any necessary specifics regarding bedtime routine. | Specify: | | | | | | | | | |  | | | | | | |  |
| What happens if this routine is disrupted? | Impact on child: | | | | | | | | | |  | | | | | | |  |
| Impact on family members: | | | | | | | | | |  | | | | | | |  |
| **FEEDING** | | | | | | | | | | |  | | | | | | |  |
| Was your child breastfed as an infant? | NO | YES | | | | | | | | |  | | | | | | |  |
| For how long? | | | | | | | | |  | | | | | | |  |
| If child was bottle fed as an infant, were there any difficulties or concerns? | NO | YES. Please comment: | | | | | | | | |  | | | | | | |  |



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| What routines do you follow that are helpful for getting your child to eat meals? | Specify: | | |  | | | | | | |  | | | |
| What happens if this routine is disrupted? | Impact on child: | | |  | | | | | | |  | | | |
| Impact on family members: | | |  | | | | | | |  | | | |
| **GROOMING** | | | |  | | | | | | |  | | | |
| Does your child dislike or resist the tactile feeling of grooming activities?  (Circle all that apply.) | Tooth Brushing | Bathing | | Hair brushing/ combing | | Face washing | | | | Haircuts |  | Nail  Trimming | | Blowing Nose |
| Please comment: | | |  | | | | | | |  | | | |
| Does your child have difficulty completing grooming activities in a coordinated manner or with adequate skill? (Circle all that apply.) | Tooth Brushing | Bathing | | Hair brushing/ combing | | Face washing | | | | Haircuts |  | Nail  Trimming | | Blowing Nose |
| Please comment: | | |  | | | | | | |  | | | |
| Does your child avoid or fear grooming devices? (Circle all that apply.) | Electric toothbrushes | |  | Barber’s clippers | | | | Dentistry tools | | |  | Other(s): | | |
| Please comment: | | |  | | | | | | |  | | | |
| Does your child avoid or fear the sounds associated with grooming activities? (Circle all that apply.) | Hair dryer | |  | Bath Water | | | Hand Dryer | | | |  | | Toilet flushing | |
| What routines do you follow that are helpful for getting your child to participate in grooming activities? | Specify: | | |  | | | | | | |  | | | |
| What happens if this routine is disrupted? | Impact on child: | | |  | | | | | | |  | | | |
| Impact on family members: | | |  | | | | | | |  | | | |
| **DRESSING** | | | |  | | | | | | |  | | | |
| Which clothing is your child able to take off independently?  (Circle all that apply.) | Shirt | Pants | |  | Underwear | | | | Shoes | | Socks | | | Coat |
| Which clothing is your child able to put on independently?  (Circle all that apply.) | Shirt | Pants | |  | Underwear | | | | Shoes | | Socks | | | Coat |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Which fasteners can your child manage independently?  (Circle all that apply.) | Snaps | | | Zippers | | Buttons (unbutton & button) | | Tie shoes | | |
| Was it a struggle learning to tie? | | |
| No | | Yes |
| Is your child selective in the types of clothing textures he/she will wear? | NO | YES | | | | | |  | | |
| What types of clothing textures are preferred? | | | | | |  | | |
| What clothing textures are avoided? | | | | | |  | | |
| Does your child express a need for minimal clothing, regardless of weather? | NO | YES. Please comment: | | | | | |  | | |
| Does your child express a need for clothing to cover entire body or dress in layers, regardless of weather? | NO | YES. Please comment: | | | | | |  | | |
| Does your child frequently adjust clothing, as if uncomfortable? | NO | YES. Please comment: | | | | | |  | | |
| Do tags in clothing or seams in socks bother your child? | NO | YES | | | | | |  | | |
| What type of reaction/behavior is seen? | | | | | |  | | |
| What routines do you follow that are helpful for getting your child to participate with dressing? | Specify: | | | | | | |  | | |
| What happens if this routine is disrupted? | Impact on child: | | | | | | |  | | |
| Impact on family members: | | | | | | |  | | |
| **TOILET TRAINING** | | | | | | | |  | | |
| Is your child currently toilet trained for bladder? | NO | YES | | | | | |  | | |
| At what age? | | | | | |  | | |
| Is your child currently toilet trained for bowel? | NO | YES | | | | | |  | | |
| At what age? | | | | | |  | | |
| Does your child experience urinary/bowel issues? (Circle all that apply.) | Incontinence during the day | | Bedwetting | | Constipation | | Loose stools |  | Lack of awareness | |
| H How often? | | How often? | | How often? | | How often? |  | How often? | |
| Does your child wear a diaper or pull-up at night? | NO | YES | | | | | |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| What routines do you follow that are helpful for getting your child to participate with toileting? | Specify: | | |  |  |  |  |
| What happens if this routine is disrupted? | Impact on child: | | |  |  |  |  |
| Impact on family members: | | |  |  |  |  |
| **SOCIAL FUNCTIONS/FAMILY LIVING** | | | |  |  |  |  |
| Are you limited in attending family/social gatherings because of your child’s behavior/ reactivity to events? | NO | YES. Please comment: | |  |  |  |  |
| Is your child unable to attend birthday parties? | NO | YES. Please comment: | |  |  |  |  |
| Are you unable to leave your child alone with familiar, but not routine, caregivers for childcare? | NO | YES. Please comment: | |  |  |  |  |
| Is your family unable to maintain relationships with other families? | NO | YES. Please comment: | |  |  |  |  |
| Is your family unable to pursue hobbies and interests? | NO | YES. Please comment: | |  |  |  |  |
| Is your child able to tolerate social touch or hugs from others? | NO | YES. Please comment: | |  |  |  |  |
| Does your child have  difficulty with different people’s voices? | NO  YES |  | |  |  |  |  |
| Loud voices | Men’s voices | Women’s voices | Children’s voices | Screaming | Crying |
| What routines do you follow that are helpful for getting your child to participate in social situations? | Specify: | | |  |  |  |  |
| What happens if this routine is disrupted? | Impact on child: | | |  |  |  |  |
| Impact on family members: | | |  |  |  |  |
| **COMMUNITY** | | | |  |  |  |  |
| Is your child unable to eat out at restaurants? | NO | YES. Please comment: | | | | | |

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| --- | --- | --- |
| Is your child  uncomfortable on  elevators, escalators, or in cars? | NO | YES. Please comment: |
| Does your child avoid busy, unpredictable environments? | NO | YES. Please comment: |
| Does your child have an excessive reaction to light touch sensation? | NO | YES |
| What types of reaction/behavior is seen? |
| Is your child unresponsive to being touched or bumped? | NO | YES |
| Does your child have an excessive reaction if bumped unexpectedly? | NO | YES. Please comment: |
| Does your child exhibit a lack of safety awareness? | NO | YES. Please comment: |
| Does your child have difficulty traveling on a variety of public transportation? | NO | YES. Please comment: |
| Does your child have difficulty flying on airplanes? | NO | YES. Please comment: |
| Is your child unable to attend sleepovers? | NO | YES. Please comment: |
| Does your child have difficulty with loud, crowded sporting events? | NO | YES. Please comment: |
| Does your child have  difficulty sitting through public performances? | NO | YES. Please comment: |
| Does your child have difficulty at sporting events (enclosed or open stadium)? | NO | YES. Please comment: |
| Does your child have difficulty in the grocery store? | NO | YES. Please comment: |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does your child have difficulty in shopping malls? | NO | YES. Please comment: | | | | | | | |
| Does your child have difficulty with long car rides? | NO | YES. Please comment: | | | | | | | |
| Does your child have difficulty standing in lines? | NO | YES. Please comment: | | | | | | | |
| **SOCIAL INTERACTION** | | | | | | | | | |
| Does your child exhibit aggressive behavior? | NO | YES | | | | | | | |
| Is it directed towards him/herself? | | | | NO | | YES | |
| Is it directed towards others? | | | | NO | | YES | |
| What types of behaviors are exhibited?  (Circle all that apply.) | | | Biting | Pinching | Kicking | Hitting | Other(s) |
| Does your child exhibit tantrums? | NO | YES | | | | | | | |
| How frequently do they occur? \_\_\_\_\_\_\_\_time/day OR \_\_\_\_\_\_\_time/week | | | | | | | |
| What triggers the tantrums? | | | | | | | |
| On average, how long does a tantrum last? | | | | | | | |
| Describe strategies that are effective for helping calm your child during a tantrum. | | | | | | | |
| Are tantrums a source of distress to other family members? | | | | NO | | YES | |
| Is your child easily frustrated, anxious, or overwhelmed? | NO | YES. Please comment: | | | | | | | |
| Is your child overly dependent on parent(s) or clingy? | NO | YES | | | | | | | |
| Are separations challenging? | | | | NO | | YES | |
| Does your child easily escalate from whimper to intense cry? | NO | YES. Please comment: | | | | | | | |
| If your child uses atypical repetitive behavior, which behaviors are demonstrated?  (Circle all that apply.) | Hand flapping | | Rocking | Head banging | | Jumping | | Smelling | |
| Breath holding | | Humming | Self-talk | | Biting | | Mouthing objects | |
| Visual fixing | | Spinning | Teeth grinding | | Other(s): | |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does your child struggle with transitions? | NO | YES | | | | | |  |
| How long does it take to transition, on average? | | | | | |  |
| What transitions are difficult? | | | Please comment: | | |  |
| What strategies are used to help ease transitions? | | | Please comment: | | |  |
| Does difficulty transitioning cause distress to family members? | | | NO | |  | YES |
| Please comment: | | |  |
| Does your child struggle when there is excessive auditory input in his/her environment? | NO | YES | | | | | |  |
| How does your child react? | | | | | |  |
| Does your child struggle around individuals with certain voice pitches? | NO | YES. Please comment: | | | | | |  |
| Does your child struggle to communicate own needs? | NO | YES. Please comment: | | | | | |  |
| What is your child’s primary form of communication? | Talking | | Singing | Sounds/  Vocalizations | | Pointing/ Gesturing | | Crying/ Screaming |
| How often does your child make eye contact during conversation? | Less than 25% of the time | | 25% of the time | 50% of the time | | 75% of the time | | 100% of the time |
| How often does your  child orient to his/her name being called? | Less than 25% of the time | | 25% of the time | 50% of the time | | 75% of the time | | 100% of the time |
| Does your child have difficulty separating from parent or caregiver? | NO | YES. Please comment: | | | | | |  |
| Does your child appear to have an awareness of others? | NO | YES | | | | | |  |
| Does your child appear to have an awareness of self? | NO | YES | | | | | |  |
| Does your child lack fear of strangers? | NO | YES | | | | | |  |
| How does your child react in new/unfamiliar situations? | Specify: | | | | | | |  |
| Does your child have difficulty paying attention in noisy environments? | NO | YES. Please comment: | | | | | |  |

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| Does your child regularly avoid initiation of social interaction? | NO | YES | | | | | | | | | | | | | | | |
| With whom? | | | | | | | | | | | | | | | |
| How often? | | | | | | | | | | | | | | | |
| Does your child avoid maintaining social interaction? | NO | YES | | | | | | | | | | | | | | | |
| With whom? | | | | | | | | | | | | | | | |
| How often? | | | | | | | | | | | | | | | |
| Does your child experience difficulties with language expression?  (Circle all that apply.) | NO | YES | | | | | | | | | | | | | | | |
| Easily frustrated, anxious, or overwhelmed | | | | | Frequently mispronounces words  (i.e. bisghetti) | | | | Poor articulation, difficult to understand | | | | | Difficulty  making choices | |
| Flat, monotonous voice | | | | | Hesitant speech | | | | Tendency to stutter | | | | | Difficulty expressing emotions verbally | |
| What routines do you follow that are helpful in getting your child to socialize? | Specify: | | | | | | | | | | | | | | | | |
| What happens if this routine is disrupted? | Impact on child: | | | | | | | | | | | | | | | | |
| Impact on family members: | | | | | | | | | | | | | | | | |
| **PLAY SKILLS/PEER INTERACTION** | | | | | | | | | | | | | | | | | |
| How long is your child able to play alone? | 1-2 minutes | | 2-5 minutes | | | | | 5-10 minutes | | | | 10-30 minutes | | | | 30+ minutes | |
| What are your child’s preferred play activities? | Specify: | | | | | | | | | | | | | | | | |
| How much time is spent daily in the following activities? | Passive activities (i.e.TV, computer, etc.) | | | | Movement activities (i.e. playground, roughhouse play, etc.) | | | | | | | | Learning/ interactive play | | | | |
| Is your child destructive towards toys? | NO | YES. Please comment: | | | | | | | | | | | | | | | |
| Does your child struggle to play alone (excluding TV watching)? | NO | YES. Please comment: | | | | | | | | | | | | | | | |
| Does your child struggle  playing with other children?  (Circle all that apply.) | NO | YES | | | | | | | | | | | | | | | |
|  | Parallel play (playing alongside other  Children) | | | | Interactive play (playing with other children) | | | Structure group play | | | | | Making friends | | | Pretend play |
|  |  |  | | | |  | | |  | | | | |  | | |  |
| Is your child preoccupied with seeking intense movement during play?  (Circle all that apply.) | NO | YES | | | | | | | | | | | | | | | |
| Spinning | | Bouncing | | | | Crashing | | Jumping | | | | | Rocking | | Other(s): |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does your child have a strong desire for structure or control? | NO | | YES. Please comment | | | | t: | | | | | | | | | |  | |
| Does your child struggle to play in familiar settings? | NO | | YES. Please comment | | | | t: | | | | | | | | | |  | |
| Does your child struggle to play in unfamiliar settings? | NO | | YES. Please comment | | | | t: | | | | | | | | | |  | |
| Which playground equipment will your child play on?  (Circle all that apply.) |  | Swings | | | Monkey bars | | | Crawl tunnels | | | Vertical climbers | | | Merry-go-round | | | Ladders | |
|  | Slide | | | Climbing wall | | | Bridges | | | Teeter totter | | | Spring riders | | | Other(s): | |
|  |  |  | | |  | | |  | | |  | | |  | | |  | |
| Which playground equipment does your child avoid?  (Circle all that apply.) |  | Swings | | | Monkey bars | | | Crawl tunnels | | | Vertical climbers | | | Merry-go-round | | | Ladders | |
|  | Slide | | | Climbing wall | | | Bridges | | | Teeter totter | | | Spring riders | | | Other(s): | |
| Does your child avoid certain types of toys (i.e. textured toys) ? | NO | | YES. Please comment: | | | | | | | | | | | | | |  | |
| Does your child exhibit  poor safety awareness or engage in activities that are potentially dangerous (i.e. jumping without regard) ? | NO | | YES. Please comment: | | | | | | | | | | | | | |  | |
| Which of the following “messy” activities does your child avoid?  (Circle all that apply.) | Sand | | | | | Playing in the grass  t | | | Finger paint | | | Play-doh | | | Glue | | Other(s): | |
| Which surfaces does your child have difficulty with? (Circle all that apply.) | Ascending stairs | | | Descending stairs | | | Grass | | | Gravel driveways | | | Woodchips | | | Sand |  | Other(s): |
| Does your child have poor depth perception (i.e. ducks or blinks when ball is thrown at him/her, difficulty with stairs)? | NO | | YES | | | |  | | | | | | | | | |  | |
| Is your child unable to pull up on the monkey bars with bent arms and legs? | NO | | YES | | | |  | | | | | | | | | |  | |
| Is your child unable to maintain bent arms and legs while moving bar to bar on the monkey bars? | NO | | YES | | | |  | | | | | | | | | |  | |

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| Which gross motor skills  does your child have difficulty with in comparison to age peers? | Hopping | | | | | Jumping | | | | Skipping | | | | Running | | | | | | Riding a tricycle/bicycle | | | |
| **SCHOOL SKILLS** | | | | | | | | | | | | | | | | | | | | | | | |
| Where does your child attend preschool or school? | Home school | | | Daycare | | | | Special needs pre-school class | | | | | Regular education class | | | | | Special education class | | | | Other: | |
| Does your child exhibit a hand preference? | NO | YES | | | | | | | | | | | | | | | | | | | | | |
| Right | | | | Left | | | | | | | | | | | | | | | | | |
| Established at what age? | | | | | | | | | | | | | | | | | | | | | |
| Does your child frequently change his/her grasp on pencils/other tools? | NO | YES | | | | | | | | | | | | | | | | | | | | | |
| Which writing skills does your child struggle with/avoid?  (Circle all that apply.) | Drawing/  Coloring | | Tracing | | | | Copying | | Handwriting | | | Use of graded pressure | | | | | | Stabilization of paper while drawing/writing | | | | | Proper desk posture |
| Too much | | | Too  little | | |
| Which fine motor skills does your child struggle with/avoid?  (Check all that apply.) | Grasping and maneuvering a scissors | | | | | | | | | | | Performing 2 different task at the same time (i.e. hold and turn paper while cutting, cut food using knife and fork) | | | | | | | | | | | |
| Which skills does your child struggle with? (Check all that apply.) | Finding items within  A “Hidden picture” | | Phonetic learning | | | Telling time | | | Sequencing months of the year | | Puzzles and construction/ manipulation of materials | | | | | | Spelling | | Responding promptly to verbal instruction | | | | Writing  numbers &  letters correctly (without frequent reversals) |
| Are your child’s drawings immature for age? | NO | | YES | | | | | | | | | | | | | | | | | | | | |
| Does your child write up/down hill on paper? | NO | | YES | | | | | | | | | | | | | | | | | | | | |
| Which of the following visual-related skills does your child struggle with?  (Circle all that apply.) | Poor eye teaming | | | | Using peripheral more than  central vision | | | | | Keeping eyes too close to work | | | | | | Closing/ covering one eye while doing near work | | | | | Eye strain after reading a short period of time | | |
| Copying from chalkboard to paper | | | | Short attention span in reading/ copying | | | | | Turning head when reading across a page | | | | | | Losing place often during reading | | | | | Needing finger or marker to keep place while reading | | |
| Reading comprehension | | | | Reverses letters or words | | | | | Rereads or skips words | | | | | | Doesn’t look when manipulating objects | | | | | Tracking a moving object with head movement | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does your child have difficulty sitting still? | No  Yes |  | | | | | | | | | | | | | | | |
| Does your child fidget while listening? | | | | | | | | | NO | | | | | YES | |
| **MOVEMENT SKILLS** | | | | | | | | | | | | | | | | | |
| Does your child become overly excited after movement activities? | NO | | YES. Please comment: | | | | | | | | | | | | | | |
| Does your child like to | NO | | YES | | | | | | | | | | | | | | |
| be wrapped tightly in a sheet or blanket, or seeks tight spaces? |  | |  | | | | | | | | | | | | | | |
| Does your child shake head vigorously or assume an upside down position frequently? | NO | | YES | | | | | | | | | | | | | | |
| Is your child able to conceive and organize a plan of action to direct play/movement? | NO | | YES | | | | | | | | | | | | | | |
| Does your child display the following movement difficulties? (Circle all that apply.) | Avoids activities where feet leave the ground | | | | | | Avoids/fears activities requiring balance | | | | | | Avoids age appropriate gross motor activities | | | | |
| Excessive dizziness from swinging, spinning, or riding in a car | | | | | | Stamps/slaps feet on ground when walking | | | | | | Loses balance/trips easily or frequently | | | | |
| Resists having head tilted backwards | | | | | | Drags feet or has poor heel-toe pattern when walking | | | | | | Unable to reciprocate feet on stairs | | | | |
| Fears falling when no real danger exists | | | | | | Drags hand or bangs object along wall when walking | | | | | | Difficulty moving from one floor surface to another | | | | |
| Fearful of being tossed in the air or turned upside down | | | | | | Lethargic or inactive | | | | | | Confuses left and right | | | | |
| Holds head upright when leaning or being over | | | | | | Leans on objects/people for stability | | | | | | Difficulty moving between rooms | | | | |
| Dislikes inversion | | | | | | Sets jaw or locks major joints for stability when applying effort | | | | | | Poor body scheme awareness | | | | |
| Poor sense of direction or awareness of space in relation to self | | | | | | Limited rotation of pelvis and/or shoulder girdle around central core  of body | | | | | | Moves with quick bursts of activities rather than sustained effort | | | | |
| Dislikes being moved | | | | | | Seems weaker or tires more easily than peers | | | | | | Poor coordination or sense of rhythm | | | | |
|  | | | | | | | | | | | | | | | | | |
| **DAILY ENVIRONMENT INTERACTION** | | | | | | | | | | | | | | | | | |
| Does your child demonstrate an irrational fear of any of the following noisy appliances?  (Circle all that apply.) | Vacuum cleaner | | Hair dryer | Fans | | Blender | | Coffee  grinder | Toilet flushing | | | Dehumidifier | | | Air vents | | Other(s): |
| Please comment: | | | | | | | | | | | | | | | | |
| Does your child demonstrate an irrational fear of any of the following noisy sounds?  (Circle all that apply.) | Jets/ Airplanes | | | | Trucks | | | | | Thunder | | | | Other(s): | | | |
| Please comment: | | | |  | | | | |  | | | |  | | | |
| Is your child confused about the direction of sounds? | NO | YES. Please comment: | | | | | | | |  | | | |  | | | |
| Does your child hear sounds that others do not or before others notice? | NO | YES. Please specify: | | | | | | | |  | | | |  | | | |
| Does your child cover ears to shut out objectionable auditory input or overreact to unexpected noises? | NO | YES. Please comment: | | | | | | | |  | | | |  | | | |
| Does your child attend to auditory input less than a few seconds? | NO | YES. Please comment: | | | | | | | |  | | | |  | | | |
| Does your child appear under or over sensitive to pain? | NO | YES. Please specify: | | | | | | | |  | | | |  | | | |
| Does your child dislike having eyes covered or being in the dark? | NO | YES. Please comment: | | | | | | | |  | | | |  | | | |
| Is your child overly sensitive to lights or sunlight? | NO | YES. Please comment: | | | | | | | |  | | | |  | | | |
| Does your child seem to need to “fix” the environment (i.e. arrange objects, chairs, etc.)? | NO | YES. Please comment: | | | | | | | |  | | | |  | | | |
| Does your child avoid environments/ objects with certain odors? | NO | YES. Please comment: | | | | | | | |  | | | |  | | | |
| Does your child seek environments/ objects with certain odors? | NO | YES | | |  | | | | |  | | | |  | | | |

Adapted from: *Listening Skills Inventory © Vital Links,2008 and Sensory History Questionnaire by Kerry Wallace*