**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 anycomplications, 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 BehaviorAnalysis (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 ahistory 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 atricycle |  | 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 childback 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/sheconsistently 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 |  | NailTrimming | 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 |  | NailTrimming | 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 |

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| --- | --- | --- | --- | --- |
| 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 havedifficulty with different people’s voices? | NOYES |  |  |  |  |  |
| 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 childuncomfortable onelevators, 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 havedifficulty 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 yourchild 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 | Difficultymaking 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 struggleplaying with other children?(Circle all that apply.) | NO | YES |
|  | Parallel play (playing alongside otherChildren) | 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): |

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| --- | --- | --- | --- | --- |
| 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 exhibitpoor 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 grasst | 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 skillsdoes 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 | Toolittle |
| 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 withinA “Hidden picture” | Phonetic learning | Telling time | Sequencing months of the year | Puzzles and construction/ manipulation of materials | Spelling | Responding promptly to verbal instruction | Writingnumbers &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 thancentral 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 |

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| --- | --- | --- |
| Does your child have difficulty sitting still? | NoYes |  |
| 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 coreof 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 | Coffeegrinder | 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*