Functional Listening Questionnaire

Date:

CONTACT INFORMATION			
Patient Name	Sex	Date of Birth	Age
Address			
City	State	Zip Code	
Email			
Phone # Home	Work	Cell	

GENERAL INFORMATION								
Were there any complications, illnesses, or stress during your mother's pregnancy?	NO	YES Please specify:						
Were there any complications during your labor or delivery?	NO	YES Please specify:						
What is your birth order?								
Please specify the conditions of your birth. (circle all that apply)	Vaginal	Forceps	Vacuum	C-section	Premature	Postmature	Full-term	
What was your birth weight?								
Please indicate age/sex of any siblings.								
Have you received Occupational therapy services in the past?	NO	YES At what age did you begin therapy? How long did/have you receive(d) therapy? How frequently were/are you seen for therapy?						
Do/Have you receive(d) other interventions?	NO	YES Please specify:						
Do you have a medical diagnosis, please specify:								
Did you have a history of ear infections as a child?	NO	YES How many? At what ages?						
Do you currently take any medications?	NO	YES Please specify:						
Do you have any allergies?	NO	YES Please specify:						
Have you experienced any major injuries or hospitalizations?	NO	YES Please specify:						

Do you wear glasses or contacts?	NO	YES				
Do you have a history of seizures?	NO	YES Please comment:				
Did you meet developmental milestones in a typical manner?						
What are your primary concerns?	Please comment:					
SLEEPING						
What time do you awaken?						
What mood are you in upon morning waking?						
What time do you go to bed?						
What time do you fall asleep?						
Do you 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?				
How many times per night do you wake?	Almost never	1-2	3-4	5-6	7+	
What activities do you use to get back to sleep?	Please specify:					
Do you seem to require too much or too little sleep or at odd times?	NO	YES				
		How many hours nightly?				
		What times of day?				
Do you take regular naps?	NO	YES				
		Frequency of naps?				
		Duration of naps?				
		Location of naps?				
FEEDING						
Did you have any feeding or reflux issues as an infant?	NO	YES Please comment:				
Did you have problems with appetite or weight gain as a child?	NO	YES Please comment:				
Did your child have respiratory problems as a child?	NO	YES Please comment:				
Do you refuse to eat or gag on foods based on the following characteristics? (circle all that apply)	NO	YES				
		Temperature	Food texture	Crunchy foods	Chewy foods	Food color	Mixed food textures
		Please comment:					

Do you show a strong preference for food based on the following characteristics? (circle all that apply)	NO	YES						
		Variety of food selection	Temperature	Food texture	Crunchy foods	Chewy foods	Food color	Mixed food textures
		Please comment:						
GROOMING								
Do you dislike or resist the tactile feeling (touch) of grooming activities? (circle all that apply)	Tooth brushing	Bathing	Hair brushing/ combing	Face washing	Haircuts	Nail trimming	Blowing nose	
	Please comment:							
Do you avoid any grooming devices? (circle all that apply)	Electric toothbrushes	Barber's clippers	Dentistry tools	Other(s):				
	Please comment:							
Are the sounds associated with grooming bothersome to you?	Hair dryer	Bath water	Hand dryer	Toilet flushing				
DRESSING								
Are you selective in the types of clothing textures you will wear?	NO	YES						
		What types of clothing textures are preferred?						
		What clothing textures are avoided?						
Do you prefer to wear minimal clothes, regardless of weather?	NO	YES Please comment:						
Do you prefer clothing to cover entire body or dress in layers, regardless of weather?	NO	YES Please comment:						
Do you frequently adjust clothing, as if uncomfortable?	NO	YES Please comment:						
Are you bothered by tags in clothing or seams in socks?	NO	YES Please comment:						
TOILETING								
Do you experience urinary/bowel issues? (circle all that apply)	Incontinence	Constipation	Loose stools	Lack of awareness				
	How often?	How often?	How often?	How often?				
SOCIAL FUNCTIONS/FAMILY LIVING								
Are you limited in attending family/social gatherings?	NO	YES Please comment:						
Do you struggle maintaining social relationships?	NO	YES Please comment:						
Are you hobbies/interests limited?	NO	YES Please comment:						

What are your hobbies or interests?	Please comment:	
How much time is spent daily in the following activities?	Passive activities (i.e. TV, computer, etc.)	Movement activities (i.e. exercise, etc.)
COMMUNITY		
Are you unable to eat out at restaurants?	NO	YES Please comment:
Are you uncomfortable on elevators, escalators, or in cars?	NO	YES Please comment:
Do you avoid busy, unpredictable environments?	NO	YES Please comment:
Do you have an excessive reaction to light touch sensation?	NO	YES What type of reaction?
Are you unresponsive to being touched or bumped?	NO	YES
Do you have an excessive reaction if bumped unexpectedly?	NO	YES Please comment:
Do you exhibit a lack of safety awareness?	NO	YES Please comment:
Do you have difficulty traveling on a variety of public transportation?	NO	YES Please comment:
Do you have difficulty flying on airplanes?	NO	YES Please comment:
Do you have difficulty with loud, crowded sporting events?	NO	YES Please comment:
Do you have difficulty sitting through public performances?	NO	YES Please comment:
Do you have difficulty in busy grocery stores or malls?	NO	YES Please comment:
Do you have difficulty with long car rides?	NO	YES Please comment:
Do you have a strong desire for structure or a need for control?	NO	YES Please comment:
SOCIAL INTERACTION		
Are you easily frustrated, anxious, or overwhelmed?	NO	YES Please comment:

How do you react in new/unfamiliar situations?	Please comment:				
Do you have any self stimulatory behaviors? (circle all that apply)	Rocking		Humming		Mouthing objects
	Smelling		Self-talk		Teeth grinding
	Breath holding		Biting		Other(s):
Do you struggle with transitions between activities?	NO	YES			
		What transitions are difficult?			
		What strategies are used to help ease transitions?			
Do you struggle when there is excessive auditory input in the environment?	NO	YES			
		How do you react?			
Do you struggle around individuals with certain voice pitches?	NO	YES Please comment:			
Do you have difficulty paying attention in noisy environments?	NO	YES Please comment:			
Do you regularly avoid initiation of social interaction?	NO	YES			
		With whom?			
		How often?			
Do you avoid maintaining social interaction?	NO	YES			
		With whom?			
		How often?			
Do you experience difficulties with language expression? (circle all that apply)	NO	YES			
		Easily frustrated, anxious, or overwhelmed	Flat, monotonous voice	Tendency to stutter	
		Difficulty making choices	Hesitant speech	Difficulty expressing emotions verbally	
VISUAL SKILLS					
Which of the following visual-related skills do you 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 board 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	Not looking when manipulating objects	Tracking a moving object with head movement
MOVEMENT SKILLS					
Do you have difficulty sitting still?	NO	YES			
		Do you need to fidget while listening?	NO	YES	
Do you like deep pressure or seek out tight spaces?	NO	YES			

Do you display the following movement difficulties? (circle all that apply)	Avoid activities where feet leave the ground	Avoid/fear activities requiring balance	Avoid gross motor activities
	Excessive dizziness from swinging, spinning, or riding in a car	Stamp/slap feet on ground when walking	Lose balance/trip easily or frequently
	Resist having head tilted backwards	Drag feet or have poor heel-toe pattern when walking	Difficulty reciprocating feet on stairs
	Fear falling when no real danger exists	Drag hands along wall when walking	Difficulty moving from one floor surface to another
	Fearful of being upside down	Lethargic or inactive	Confuse left and right
	Hold head upright when leaning or being over	Lean on objects/people for stability	Difficulty moving between rooms
	Dislike inversion	Set jaw or lock major joints for stability when applying effort	Poor body scheme awareness
	Dislike being moved	Limited rotation of pelvis and/or shoulder girdle around central core of body	Move with quick bursts of activities rather than sustained effort
	Poor sense of direction or awareness of space in relation to self	Seem weak and/or fatigue quickly	Poor coordination or sense of rhythm

DAILY ENVIRONMENT INTERACTION

Do you 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	Dehumi difier	Air vents	Other(s):
	Please comment:								
Do you demonstrate an irrational fear of any of the following noisy sounds? (circle all that apply)	Jets/ Airplanes		Trucks		Thunder			Other(s):	
	Please comment:								
Are you often confused about the direction of sounds?	NO	YES Please comment:							
Do you hear sounds that others do not or before others notice?	NO	YES Please specify:							
Do you cover ears to shut out objectionable auditory input or overreact to unexpected noises?	NO	YES Please comment:							
Do you attend to auditory input less than a few seconds?	NO	YES Please comment:							
Do you appear under or over sensitive to pain?	NO	YES Please specify:							
Do you dislike having eyes covered or being in the dark?	NO	YES Please comment:							

Are you overly sensitive to lights/sunlight?	NO	YES Please comment:
Do you need to "fix" the environment (i.e. arrange objects, chairs, etc.)?	NO	YES Please comment:
Are you bothered by certain odors?	NO	YES Please comment: