Functional Listening Questionnaire

Date:

<table>
<tr><td colspan="5">CONTACT INFORMATION</td></tr>
<tr><td colspan="2">Client's Name</td><td colspan="2">Gender</td><td>DOB</td><td>Age</td></tr>
<tr><td colspan="6">Parent'(s) Names</td></tr>
<tr><td colspan="6">Address</td></tr>
<tr><td colspan="2">City</td><td colspan="3">State</td><td>Zip</td></tr>
<tr><td colspan="2">Email</td><td colspan="4">Home Phone</td></tr>
<tr><td colspan="2">Cell #</td><td colspan="4">Education Level</td></tr>
<tr><td colspan="6">GENERAL INFORMATION</td></tr>
<tr><td>Were there any complications, illnesses, trauma, or stress to the client or family members from infanthood to the present?</td><td>NO</td><td colspan="4">YES: Please specify.</td></tr>
<tr><td>If the client has a medical diagnosis, please specify:</td><td>NO</td><td colspan="4">YES. Please specify:</td></tr>
<tr><td>Does the client currently take any medications?</td><td>NO</td><td colspan="4">YES. Please specify:</td></tr>
<tr><td>What is the client's birth order?</td><td colspan="5"></td></tr>
<tr><td>Please indicate age/gender of any siblings.</td><td colspan="5"></td></tr>
<tr><td rowspan="4">Has the client received Occupational Therapy services in the past?</td><td rowspan="4">NO</td><td>YES</td><td colspan="3">At what age did the client begin therapy?</td></tr>
<tr><td rowspan="3"></td><td colspan="3">What goals were met?</td></tr>
<tr><td colspan="3">How frequently was the client seen for therapy?</td></tr>
<tr><td colspan="3">How long did the client receive therapy?</td></tr>
</table>

<table>
<tr><td rowspan="2">Has the client received other interventions?
(Circle all that apply.)</td><td rowspan="2">NO</td><td rowspan="2">YES</td><td>Speech Therapy</td><td>Physical Therapy</td><td>Applied Behavior Analysis (ABA)</td><td>DIR Floortime</td><td>Other(s):</td></tr>
<tr><td>How long?</td><td>How long?</td><td>How long?</td><td>How long?</td><td>How long?</td></tr>
<tr><td>What goals were met while receiving the above interventions?</td><td colspan="7"></td></tr>
<tr><td>As a child was the client developmentally or physically delayed?</td><td>NO</td><td colspan="6">YES. Please specify:</td></tr>
<tr><td>Has the client experienced any major injuries or hospitalizations?</td><td>NO</td><td colspan="6">YES. Please specify:</td></tr>
<tr><td>Does the client have a history of seizures?</td><td>NO</td><td colspan="6">YES. Please comment:</td></tr>
<tr><td>What are the client’s primary concerns?</td><td colspan="7">Please comment:</td></tr>
<tr><td>What is/are the hardest time(s) of day?</td><td colspan="7">Please comment:</td></tr>
<tr><td>Describe the impact on daily functioning:</td><td colspan="7">Please comment:</td></tr>
</table>

SLEEPING

<table>
<tr><td>How many hours of sleep does the client receive per night?</td><td colspan="3"></td></tr>
<tr><td>Does the client have trouble falling asleep?</td><td>NO</td><td colspan="2">YES</td></tr>
<tr><td>How many times per night does the client awaken?</td><td>Almost never</td><td>1-2</td><td>3+</td></tr>
<tr><td>Describe the clients routines that are helpful for falling back asleep:</td><td colspan="3"></td></tr>
<tr><td>Does the client take naps?</td><td>NO</td><td colspan="2">YES</td></tr>
</table>

<table>
<tr><td rowspan="2"></td><td rowspan="2"></td><td colspan="6">Frequency of naps:</td></tr>
<tr><td colspan="6">Duration of naps:</td></tr>
<tr><td>Please describe any necessary specifics the client does before going to sleep.</td><td colspan="7"></td></tr>
<tr><td>What happens if this routine is disrupted?</td><td colspan="7">Impact on client:</td></tr>
<tr><td colspan="8">FEEDING</td></tr>
<tr><td>Was the client breastfed as an infant?</td><td>NO</td><td colspan="6">YES. For how long?</td></tr>
<tr><td>Did the client have problems with appetite or weight gain as a child?</td><td>NO</td><td colspan="6">YES. Please comment:</td></tr>
<tr><td rowspan="3">Does the client refuse to eat, or spit out certain foods based on the following characteristics? (Circle all that apply.)</td><td rowspan="3">NO</td><td colspan="6">YES</td></tr>
<tr><td>Tempera
-ture</td><td>Food texture</td><td>Crunchy foods</td><td>Chewy foods</td><td>Food color</td><td>Mixed food textures</td></tr>
<tr><td colspan="6">Please comment:</td></tr>
<tr><td>Does a noisy environment affect the client’s eating habits at mealtime?</td><td>NO</td><td colspan="6">YES. Please comment:</td></tr>
<tr><td>Does it distract or bother the client when others chew and crunch their food at mealtimes?</td><td>NO</td><td colspan="6">YES. Please comment:</td></tr>
<tr><td colspan="8">GROOMING</td></tr>
<tr><td colspan="2">Does the client refrain from engaging in certain grooming activities because he/she dislikes the tactile feeling such as brushing teeth, nail cutting and face washing?</td><td colspan="6">Specify:</td></tr>
<tr><td colspan="2">What routines does the client follow that are helpful to engage in grooming activities?</td><td colspan="6">Specify:</td></tr>
<tr><td colspan="2">What happens if this routine is disrupted?</td><td colspan="6">Impact on client:</td></tr>
</table>

<table>
<tr><td colspan="4">DRESSING</td></tr>
<tr><td>Is the client selective in the types of clothing textures he/she will wear?</td><td>NO</td><td>YES</td><td>What types of textures are preferred?</td></tr>
<tr><td>Does tags on clothing bother the client?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Does the client refrain from wearing stockings?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Does tight or loose fitting clothing bother the client?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Does elastic waist bands bother the client?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td colspan="4">SOCIAL FUNCTIONS/FAMILY LIVING</td></tr>
<tr><td>Is the client limited in attending family/social gatherings because of behavior/ reactivity to events?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Is the client’s family unable to maintain relationships with other families?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Does the client avoid social/family events because he/she has difficulty with crowded environments?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty socializing in a loud talkative group at family/social gatherings?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Is the client able to tolerate social touch or hugs from others?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty with different types of voices at social/family gatherings?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td colspan="4">COMMUNITTY</td></tr>
<tr><td>Is the client unable to eat out at restaurants?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Is the client uncomfortable on elevators, escalators, or in cars?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
<tr><td>Does the client avoid, busy, unpredictable environments?</td><td>NO</td><td colspan="2">YES. Please comment:</td></tr>
</table>

<table>
<tr><td>Does the client have an exaggerated reaction to light touch sensation?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client have an excessive reaction if bumped unexpectedly?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty traveling on public transportation?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty flying on airplanes?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty with long car rides and/or sitting in the back seat?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty with loud, crowded events?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty shopping at malls?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty waiting in line at a store?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td colspan="5">SOCIAL INTERACTION</td></tr>
<tr><td rowspan="3">Does the client exhibit aggressive or controlling behavior?</td><td rowspan="3">NO</td><td colspan="3">YES</td></tr>
<tr><td>Is it directed towards him/herself?</td><td>NO</td><td>YES</td></tr>
<tr><td>Is it directed towards others?</td><td>NO</td><td>YES</td></tr>
<tr><td rowspan="3">Does the client exhibit tantrums or other acting out behaviors?</td><td rowspan="3">NO</td><td colspan="3">YES</td></tr>
<tr><td colspan="3">What triggers the tantrums?</td></tr>
<tr><td>Are tantrums a source of distress to other family members?</td><td>NO</td><td>YES</td></tr>
<tr><td>Does the client easily experience feelings of frustration or anxiety?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Is the client dependent on others?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client experience a negative reaction when there is excessive noise in the environment?</td><td>NO</td><td colspan="3">YES. Please comment:</td></tr>
<tr><td>Does the client struggle to express his/her own needs?</td><td>NO</td><td colspan="3">YES</td></tr>
</table>

<table>
<tr><td>Does the client make eye contact when conversing with others?</td><td>NO</td><td colspan="4">YES</td></tr>
<tr><td>Does the client struggle around individuals with certain voice pitches?</td><td>NO</td><td colspan="4">YES. Please comment:</td></tr>
<tr><td>Does the client experience fear or anxiety around new people?</td><td>NO</td><td colspan="4">YES. Please comment:</td></tr>
<tr><td>Does the client have difficulty initiating when conversing with others?</td><td>NO</td><td colspan="4">YES. Please comment:</td></tr>
<tr><td>Does the client have an awareness of others?</td><td>NO</td><td colspan="4">YES</td></tr>
<tr><td>Does the client appear to have an awareness of self?</td><td>NO</td><td colspan="4">YES</td></tr>
<tr><td>Does the client lack fear of strangers?</td><td>NO</td><td colspan="4">YES</td></tr>
<tr><td>How does the client react in new/unfamiliar situations?</td><td colspan="5">Specify:</td></tr>
<tr><td>Does the client have difficulty paying attention in noisy environments?</td><td>NO</td><td colspan="4">YES. Please comment:</td></tr>
<tr><td rowspan="2">Does the client avoid maintaining social interaction?</td><td rowspan="2">NO</td><td colspan="4">YES</td></tr>
<tr><td colspan="4">With whom?</td></tr>
<tr><td rowspan="3">Does the client experience difficulties with language expression? (Circle all that apply.)</td><td rowspan="3">NO</td><td colspan="4">YES</td></tr>
<tr><td>Easily frustrated, anxious, or overwhelmed</td><td>Frequently mispronounces words (i.e. bisghetti)</td><td>Poor articulation, difficult to understand</td><td>Difficulty making choices</td></tr>
<tr><td>Flat, monotonous voice</td><td>Hesitant speech</td><td>Tendency to stutter</td><td>Difficulty expressing emotions verbally</td></tr>
<tr><td colspan="6">PEER INTERACTION</td></tr>
<tr><td>What are the client’s preferred leisure activities with peers?</td><td colspan="5">Specify:</td></tr>
</table>

Does the client have a strong desire for control with peers?	NO	YES. Please comment:
Does the client have difficulty understanding others?	NO	YES. Please comment:
Does the client have difficulty expressing his/her own needs, ideas or emotions to peers?	NO	YES. Please comment:

SCHOOL/WORK SKILLS

Does the client exhibit a hand preference?	NO	YES. Specify:	Established at what age?

Which writing skills does the client struggle with/avoid? (Circle all that apply.)	Proper desk posture	Use of graded pressure: Too much/ Too little Pen Pressure

Which of the following visual-related skills does the client 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
	Reading comprehens-ion	Reverses letters or words	Rereads or skips words	Doesn't look when manipulating objects	Tracking a moving object with head movement
	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

Does the client have difficulty sitting still?	NO	YES. Please comment:
Does the client fidget while listening?	NO	YES. Please comment:

MOVEMENT SKILLS

Does the client become overly excited after movement	NO	YES. Please comment:

activities?				
Does the client like to be wrapped tightly in a sheet or blanket, or seek tight spaces?	NO	YES		
Is the client able to conceive and organize a plan of action to direct play/movement?	NO	YES		
Does the client display the following movement difficulties? (Circle all that apply.)	NO	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 back-wards	Drags feet or has poor heel-toe pat-tern 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
		Holds head upright when leaning or bent 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 activi-ties rather than sustained effort

		Dislikes being moved	Seems weaker or tires more easily than peers	Poor coordination or sense of rhythm
DAILY ENVIRONMENT INTERACTION				
Is the client confused about the direction of sounds?	NO	YES. Please comment:		
Does the client hear sounds that others do not or before others notice?	NO	YES. Please specify:		
Does the client cover ears to shut out objectionable auditory input or overreact to unexpected noises?	NO	YES. Please comment:		
Does the client seem under or over sensitive to pain?	NO	YES. Please specify:		
Does the client dislike having eyes covered or being in the dark?	NO	YES. Please comment:		
Is the client overly sensitive to lights or sunlight?	NO	YES. Please comment:		
Does the client seem to need to "fix" the environment (i.e. arrange objects, chairs, etc.)?	NO	YES. Please comment:		
Does the client avoid environments/ objects with certain odors?	NO	YES. Please comment:		
Does the client seek environments/ objects with certain odors?	NO	YES. Please comment:		

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