12545 Orange Drive - Suite 502
Davie, Florida 33330

BreakthroughTherapyServices
DEVELOPMENTAL BREAKTHROUGHS FOR CHILDREN
www.breakthroughtherapyservices.com

Phone: (954) 474 - 8048
Fax: (954) 474 - 8145
info@breakthroughtherapyservices.com

FUNCTIONAL LISTENING QUESTIONAIRE

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 condition 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 was your child's Apgar score?	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:								
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 you child have a history of seizures?	NO	YES Please comment:						
Please note the approximate age when your child achieved these following skills.	Sitting	Belly crawling	Crawling	Cruising	Walking	First Words	Talking	
	Hoping	Jumping	Skipping	Running	Riding a Tricycle	Riding a 2-wheel Bike	Jump Rope	
What are your primary concerns?	Please comment:							
What is/are the hardest time(s) of the 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 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 sleep issues?						
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	Scream	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 man hours nightly?						
		What times of day?						
Does your child take naps?	NO	YES						
		Frequency of naps?						
		Duration of naps?						
		Location of nap?						
		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:						
Did your child have a strong suck as an infant?	NO	YES. Please comment:						
Did your child frequently spit up as an infant or have reflux?	NO	YES. Please comment:						
Did your child have problems with appetite or weight gain as an infant?	NO	YES. Please comment:						
Did your child have respiratory problems as an infant?	NO	Yes. Please comment:						
Does your child refuse to eat, spit out, or gag on foods based on the following characteristics? (Circle all that apply)	NO	YES						
		Temperature	Food texture	Crunchy foods	Chewy Food	Food color	Mixed Food Textures	

		Please Comment:
Does your child have difficulty with ingesting foods? (Circle all that apply)	NO	YES Chewing variety of foods | Sucking through a straw | Swallowing a variety of foods | Food Falling out of mouth | Frequent choking | Managing mixed food Textures YES. Please comment:
Is there a disruption in family mealtime as a result of atypical eating patterns?	NO	YES. Please comment:
Does your child exhibit oral motor sensitivities or seeking? (Circle all that apply)	NO	YES Examines objects by placing in mouth. | Gags/vomits frequently. | Bites or chews objects/ clothing Frequently. | Grinds Teeth
Does your child attempt to eat unusual, noxious, or inedible substances or place in mouth?	NO	YES. Please comment:
Does your child have difficulty with swallowing?	NO	1-2 minutes | 3-5 minutes | 6-10 minutes | Entire meal Does this impact the quantity of food ingested? Yes | No How does this impact harmony at mealtimes? Please comment:
Where does your child eat meals?		Specify:
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)	NO	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)	NO	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)	NO	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)	NO	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 type of clothing textures he/she will wear?	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:
Do tags in clothing or seams in socks bother your child?	NO	Yes
		What type of behavior is seen?
What routines do you follow that are helpful for getting your child to participate in 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/bowl issues? (Circle all that apply.)	NO	Inconsistence during the day	Bedwetting	Constipation	Loose Stools	Lack of awareness
		How often?	How often?	How often?	How often?	How often?
Does your child wear a diaper or pull-up?	NO	YES				
What routines do you follow that are helpful for getting your child to participate with toilet?	Specify:					
What happens if this routine is interrupted?	Impact on child:					
	Impact on family members:					

SOCIAL FUNCTION/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 child alone with familiar, but not routine caregivers for childcare?	NO	YES. Please comment:
Is you family unable to pursue hobbies and interests?	NO	YES. Please comment:
Is your family unable to maintain relationships with other families?	NO	YES. Please comment:
Is your child unable to tolerate social touch or hugs from others?	NO	YES. Please comment:
Does your child have difficulty with different	NO	YES

peoples' voices?		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:					
Is your child uncomfortable on elevators, escalators, or in cars?	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. Please comment:					
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? (enclosed or open stadium)	NO	YES. Please comment:					
Does your child have difficulty sitting through public performance?	NO	YES. Please comment:					
Does your child have difficulty at the grocery store?	NO	YES. Please comment:					
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?			YES		NO
		Is it directed towards others?			YES		NO
		What types of behaviors are exhibited? (Circle all that apply)	Biting	Pinching	Kicking	Hitting	Other(s)
Does your child exhibit tantrums?	NO	YES					
		How often do they occur? _____times/day or _____ times/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)
Does your child struggle when there is excessive auditory input in his/her environment?	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 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 conversations?	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 self?	NO	YES					
Does your child lack fear of strangers?	NO	YES					
How does your child react to new/unfamiliar situations?	Specify:						
Does your child have difficulty paying attention in noisy environments?	NO	YES. Please comment:					
Does your child regularly avoid initiation of social interaction?	NO	YES					
		With whom?					
		How often?					
Does your child experience difficulty 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, ect.)	Movement activities (i.e. play-ground, roughhouse play, ect)	Learning/ Interactive play		

Is your child destructive towards toy?	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:				
Does your child struggle to play in familiar settings?	NO	YES. Please comment:				
Does your child struggle to play in unfamiliar settings?	NO	YES. Please comment:				

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 "mess" activities does your child avoid?	Sand	Playing in grass	Finger paint	Play-doh	Glue	Other(s):

Which surface does your child have difficulty with? (Circle all that apply)	Ascending stairs	Descending stairs	Grass	Gravel driveways	Woodchips	Sand	Others(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 when moving bar to bar on the monkey bars?	NO	YES

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 skill does your child struggle with/avoid?	Grasping and maneuvering scissors	Performing 2 different tasks 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	Reverse letters or words	Rereads or skips words	Doesn't look when manipulating objects	Tracking moving objects 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 be wrapped tightly in a sheet or blanket, or seek tight spaces?	NO	YES
Does your child shake head vigorously or assume an upside 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
	Fear falling when no real danger exists	Drags hand or bangs object along wall when walking	Difficulty moving from one floor surface to another
	Fearful or being tossed in the air or turned upside down	Lethargic or inactive	Confuses left and right

(Cont.)	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 that direction of sound?	NO	YES. Please comment:							
Does your child hear sounds that others do not or before others notice?	NO	YES. Please comment:							
Does your child cover ears to shut out objectionable auditory input or overreact to unexpected noise?	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 comment:							
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, ect.)	NO	YES. Please comment:							
Does your child avoid environment/objects with certain odors?	NO	YES. Please comment:							
Does your child seek environments/ objects with certain odors?	NO	YES. Please comment:							