



# Gerken Family Chiropractic

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THERAPEUTIC LISTENING® QUESTIONNAIRE				
CONTACT INFORMATION				
Child's Name:		Sex:	Date of Birth:	Age:
Parent(s) Name(s):				
Address:				
City:		State:	Zip Code:	
Email:				
Home Phone:		Work Phone:	Cell Phone:	
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?		What was your child's birth weight?		
Please specify the conditions of your child's birth. (Circle all that apply.)	Vaginal		Vacuum	Premature
	Forceps		C-section	Full Term
Other:				
What were your child's Apgar scores?		At 1 minute:		At 5 minute:
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 received therapy?		
		How frequently was/is your child seen for therapy?		
Has/Does your child receive other therapy? (Circle all that apply.)	No	Speech Therapy		How Long?
		Physical Therapy		How Long?
		Applied Behavior Analysis (ABA)		How Long?
		DIR (Floortime)		How Long?
		Other?		How Long?

Helping Children, Adults and Families Reach Their Full Potential

Donald G. Gerken, DC, DACCP, CST, Adrienne L. Young, DC, Diane Gerken, DC, Claudette Robbins, LMT

Visit our Website at [GerkenFamilyChiropractic.com](http://GerkenFamilyChiropractic.com)

If the child has a Medical diagnosis, please specify:			
Does your child have a history of ear infections?	No	How many?	
		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 specify:	
Please note the approximate age when your child achieved the following skills.	Sitting		Belly Crawling
	Cruising		Walking
	Talking		Hopping
	Skipping		Running
	Biking		Jump rope
What are your primary concerns?			
What is/are the hardest time(s) of day?			
Describe the impact on the child and other family members.			
<b>SLEEPING</b>			
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?			
Have you ever used a whit noise machine to help put your child to sleep?	No	Yes. Please specify:	
Do you currently use a white noise machine to help put your child to sleep?	No	Yes. Please specify:	
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?	

How many times does your child wake/night?	None				
What does your child do when he/she awakens?	N/A	Whimper	Scream	Play with toys	Other
		Puts self back to sleep		Goes to parents bedroom	
What activities do you use to get your child back to sleep?	N/A	Feeding	Singing	Humming	Holding
		Rocking	Bouncing	Massage	Other
Describe your routines that are helpful for getting your child back to sleep.	N/A				
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				
Does your child take naps?	No	How many per day?	Duration?	Location?	
		Does your child need help to fall asleep for naps?			
What activities do you use as part of your child's bedtime routine?	Bath time	Singing/Humming	Reading	Holding	
	Bouncing	Massage	Rocking	Other?	
Please describe any necessary specifics regarding bedtime routine.	Specify:				
What happens if this routine is disrupted?	Impact on child?				
	Impact on family members?				
<b>FEEDING</b>					
Was your child breastfed?	No	How long?			
Were there any problems or concerns with the bottle?	N/A	Explain			
Did your child have a strong suck as an infant?	Yes	No, 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	Food texture	Crunchy foods	Chewy foods	Mixed food textures			
		Temperature	Food color	Variety of food selection	Other:			
		Please comment						
Does your child have difficulty with ingesting foods? (Circle all that apply.)	No	Chewing a variety of foods	Sucking through a straw	Swallowing a variety of foods	Food falling out of mouth	Frequent choking	Managing mixed food textures	
		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, Please comment						
		Examines objects by placing in mouth	Gags/vomits frequently	Bites or chews objects or 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 eating?	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?						
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:							
<b>GROOMING</b>								
Does your child dislike or resist the tactile	No	Tooth brushing	Bathing	Hair brushing/ combing	Face Washing	Haircuts	Nail Trimming	Blowing Nose

feeling of grooming activities? (Circle all that apply.)		Please Comment:						
Does your child have difficulty completing grooming activities in a coordinated manner or with adequate skill?	No	Tooth brushing	Bathing	Hair brushing/ combing	Face Washing	Haircuts	Nail Trimming	Blowing Nose
Does your child avoid or fear grooming devices? (Circle all that apply.)	No	Electric toothbrushes		Barber's clippers	Dentistry Tools		Other:	
		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	
		Please Comment:						
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:							
<b>DRESSING</b>								
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?	Snaps				Tie Shoes			
	Zippers				Was it a struggle learning to tie?			
	Buttons (Unbutton and button)				Yes		No	
Is your child selective in the types of clothing textures he or 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 the 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 or 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 or bowel issues?	No	Bedwetting. How often?
		Constipation. How often?
		Lack of awareness. How often?
		Loose stools. How often?
		Incontinence during the day. How often?
Does your child wear a diaper or pull-up at night?	No	Yes
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 or social gatherings because of your child's behavior or 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 some people's voices?	No	Loud voices	Men's voices	Women's Voices	Children's Voices	Screaming	Crying	Other:
What routines do you follow that are helpful for getting your child to participate with 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 avoid, busy, unpredictable environments?	No	Yes, please comment						

Does your child have an excessive reaction to light touch sensation?	No	Yes. What type of reaction or 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?	No	Yes, please comment
Does your child have difficulty sitting through a public performance?	No	Yes, please comment
Does your child have difficulty at sporting events?	No	Yes, (enclosed or open stadium)
Does your child have difficulty in 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	Is it directed at himself or 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:		
Does your child exhibit tantrums?	No	Yes. How frequently do they occur?	Times/day or		times/week	
		What triggers the tantrums?				
		On average, how long do they last?				
		Are the tantrums a source of distress to others family members?				
		Describe the strategies that are effective for helping calm your child during a tantrum?				
Is your child easily frustrated, anxious, or overwhelmed?	No	Yes, please comment				
Is your child overly dependent on parent(s) or clingy?	No	Yes, please comment				
Does your child easily escalate from whimper to intense cry?	No	Yes, please comment				
Does your child use atypical repetitive behavior? (Circle all that apply.)	No	Teeth Grinding	Rocking	Head banging	Jumping	Smelling
		Breath Holding	Humming	Self-talk	Biting	Hand flapping
		Mouthing Objects	Spinning	Visual fixing	Other	
Does your child struggle when there is excessive auditory input in his or her environment?	No	How long does it take for your child to settle down on average?				
		Does this difficulty transitioning cause distress to family members? Explain:				
		What transitions are difficult? Explain				
		What strategies are used to help ease transitions? Explain				
Does your child struggle when there is excessive auditory input in his or 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 his or her own needs?	No	Yes, please comment				
What is your child's primary form of communication?		Talking	Singing	Sounds or Vocalizations	Pointing or Gesturing	Crying or Screaming
Does your child make eye contact during conversation?	Yes No	100% of the time	75% of the time	50% of the time	25% of the time	Less than 25% of the time
How often does your child orient to his or her name being called?	Yes No	100% of the time	75% of the time	50% of the time	25% of the time	Less than 25% 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, please comment				
Does your child appear to have an awareness of self?	No	Yes, please comment				
Does your child lack fear of strangers?	No	Yes, please comment				
How does your child react in new or 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, please comment				
		With whom?				
		How often?				
Does your child avoid maintaining social interaction?	No	Yes, please comment				
		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 for 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	6 – 10 minutes	11 – 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, swimming)		Learning or interactive play
Is your child destructive towards his or her 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	Making friends	Pretend play	Structure group play	
		Parallel play or playing alongside other children	Interactive play or playing alongside other children	Other:	
Is your child pre-occupied with seeking intense movement during play? (Circle all that apply.)	No	Spinning	Bouncing	Crashing	
		Jumping	Rocking	Other:	
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 walls	Bridges	Teeter totter	Spring riders	Other:
Which playground equipment does your child avoid? (Circle all that apply.)	Swings	Monkey bars	Crawl tunnels	Vertical climbers	Merry-go-round	Ladders
	Slide	Climbing walls	Bridges	Teeter totter	Spring riders	Other:
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				
Does your child avoid "messy" activities? (Circle all that apply.)	No	Sand	Playing in the grass		Finger paint	
		Play-dough	Glue		Other:	
Does your child have difficulty with surfaces? (Circle all that apply.)	No	Ascending Stairs	Descending Stairs	Grass		Gravel driveways
		Woodchips	Sand	Other:		
Does your child have poor depth perception (i.e. ducks or blinks when ball is thrown at him or her, difficulty with stairs)?	No	Yes, please comment				
Is your child unable to pull up on the monkey bars with bent arms and legs?	No	Yes, please comment				
Is your child unable to maintain bent arms and legs while moving bar to bar on the monkey bars?	No	Yes, please comment				

Does your child have difficulty with gross motor skills compared to kids his or her same age? (Circle all that apply.)	No	Hopping	Jumping	Skipping	
		Running	Riding a Tricycle or bicycle	Other:	
<b>SCHOOL SKILLS</b>					
Where does your child attend pre-school or school?	N/A	Home school	Daycare	Special Needs preschool Class	
		Regular education class	Special needs education class	Other:	
Does your child exhibit a hand preference?	No	Yes, established at what age?			
		Right	Left		
Does your child frequently change his or her grasp on pencils or other tools?	No	Yes, please comment			
Does your child struggle with or avoid writing skills? (Circle all that apply)	No	Drawing or Coloring	Tracing	Copying	Handwriting
		Too much graded pressure	Too little graded pressure	Stabilization of paper	Proper desk posture
Does your child struggle with or avoid fine motor skills?	No	Grasping and maneuvering the scissors		Performing 2 different tasks at the same time (i.e. holding and turning the paper while cutting, cutting food using a knife and fork)	
Does your child struggle with these skills? (Circle all that apply.)	No	Finding items within a "hidden picture"	Phonetic learning	Sequencing months of the year	
			Spelling	Responding promptly to verbal instruction	
			Telling time	Writing numbers & letters correctly (without frequent reversals)	
Puzzles and construction or manipulation of materials					
Are your child's drawings immature for age?	No	Yes, please comment			
Does your child write up or down hill on the paper?	No	Yes, please comment			
Does your child struggle with any of the following visual-related skills? (Circle all that apply.)	No	Poor eye training			
		Reading comprehension			
		Keeping eyes too close to work			
		Reverses letter or words			
		Copying from chalkboard to paper			
		Short attention span in reading or copying			
		Turning head when reading across a page			
Losing place often during reading					

		Eye strain after reading a short period of time Needing finger to keep place while reading Closing or covering one eye while reading Rereads or skips words Using peripheral more than central vision Doesn't look when manipulating objects Tracking a moving object with head movement Other:
Does your child have difficulty sitting still?	No	Yes, please comment
<b>MOVEMENT SKILLS</b>		
Does your child display the following movement difficulties? (Circle all that apply.)	No	Avoids activities where his or her feet leave the ground Experiences excessive dizziness from swinging, spinning, or riding in a car Resists having head tilted backwards Fears falling when no real danger exists Fearful of being tossed in the air or turned upside down Holds head upright when leaning or bending over Poor sense of direction or awareness of space in relation to self Dislikes inversion Dislikes being moved Avoids/fears activities requiring balance Stamps/slaps feet on ground when walking Drags feet or has poor heel-toe pattern when walking Unable to alternate right foot and left foot when climbing up stairs Drags hand or bangs object along wall when walking Lethargic or inactive Leans on objects/people for stability Sets jaw or locks major joints for stability when applying effort Limited rotation of pelvis or shoulder girdle around central core of body Seems weaker or tires more easily than peers Avoids age appropriate gross motor activities Loses balance/trips easily or frequently Difficulty moving from one floor surface to another Confuses left and right Difficulty moving between rooms Poor body scheme awareness Moves with quick bursts of activities rather than sustained effort Poor coordination or sense of rhythm
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 seeks tight spaces?	No	Yes, please comment			
Does your child shake his or her head vigorously or assume an upside down position frequently?	No	Yes, please comment			
Is your child able to conceive and organize a plan of action to direct play?	No	Yes, please comment			
DAILY ENVIRONMENT INTERACTION					
Does your child demonstrate an irrational fear of any of the following noisy appliances?	No	Vacuum Cleaner		Hair dryer	
		Blender		Coffee grinder	
		Dehumidifier		Air vents	
Does your child demonstrate an irrational fear of any of the following noisy sounds?	No	Jets or airplanes		Trucks	
		Thunder		Other	
		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 comment			
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	No	Yes, please comment			

the dark?		
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 or objects with certain odors?	No	Yes, please comment
Does your child seek environments or objects with certain odors?	No	Yes, please comment

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