

Auditory Integration Training

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CHILD QUESTIONNAIRE

Please state your expectations from this training:

Why do you think you or your child needs AIT?

CLIENT NAME _____ AGE _____ DATE OF BIRTH _____

GUARDIAN'S NAMES _____

HOME ADDRESS _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL ADDRESS _____

SCHOOL ATTENDING _____ GRADE/PLACEMENT _____

DDD SERVICE COORDINATOR _____

PEDIATRICIAN _____ NEUROLOGIST _____

OTHER DOCTORS/TREATMENTS _____

DIAGNOSIS/DISABILITY _____

BIRTH HISTORY FULL TERM _____ PREMATURE _____ # OF WEEKS _____

BIRTH WEIGHT _____ TIME IN HOSPITAL AT BIRTH _____

PROBLEMS WITH PREGNANCY OR BIRTH _____

OTHER HOSPITALIZATIONS _____

NUMBER OF EAR INFECTIONS MANY _____ SOME _____ FEW _____

MOST RECENT HEARING ASSESSMENT _____ RESULTS _____

P.E. TUBES _____ ENT VISITS _____

TONSILS OR ADENOIDS REMOVED _____

SEIZURES _____ WHAT KIND/HOW OFTEN _____

EEG _____ CAT SCAN _____ MRI _____

MEDICAL INSURANCE: _____

CLAIMS ADDRESS: _____

ID NUMBER: _____ GROUP NUMBER _____

NAME OF INSURED: _____

NAME OF EMPLOYER OF INSURED: _____

RECEIVING PHYSICAL THERAPY _____ NAME OF THERAPIST _____

OCCUPATIONAL THERAPY _____ NAME OF THERAPIST _____

SPEECH THERAPY _____ NAME OF THERAPIST _____

OTHER THERAPIES _____

SIBLINGS NAMES/AGES _____

PETS _____

HANDEDNESS RIGHT _____ LEFT _____ BOTH _____ CHANGES _____

ANY FOOD ALLERGIES _____

ENVIRONMENTAL OR OTHER ALLERGIES _____

ASTHMA _____ CURRENTLY TAKING ANY MEDICATIONS _____

LIST MEDICATIONS PRESCRIBED BY FOR

VERBAL_____NON VERBAL_____SIGN LANGUAGE_____

AUGMENTATIVE DEVICE_____

HAS YOUR CHILD MADE PROGRESS IN THE LAST THREE MONTHS_____

WHAT ARE HIS/HER FAVORITE FOODS?_____

FOODS CHILD REFUSES_____

FAVORITE TOYS_____

FAVORITE TV SHOWS/MOVIES_____

OTHER FAVORITE THINGS:_____

BEHAVIOR CHECKLIST

Please behaviors that you or your child currently exhibit and give a severity rating from 1 (mild) to 5 (severe). Please X behaviors seen when he/she was younger. Not all questions will apply to your child. Please feel free to write in extra information.

MOVEMENT:

- | | |
|---|-----------|
| _____ problems with balance, equilibrium or coordination | 1 2 3 4 5 |
| _____ strong preference for sitting in corner or next to a wall | 1 2 3 4 5 |
| _____ poor posture, slouches or droops | 1 2 3 4 5 |
| _____ stays in perpetual motion | 1 2 3 4 5 |
| _____ flits from one activity to another | 1 2 3 4 5 |
| _____erratic, impetuous movements | 1 2 3 4 5 |
| _____ freezes or stops when walking | 1 2 3 4 5 |
| _____ climbs on furniture | 1 2 3 4 5 |
| _____ spends time under tables or pillows | 1 2 3 4 5 |
| _____ repetative body movements | 1 2 3 4 5 |
| _____ flaps hands, finger, arms or other objects | 1 2 3 4 5 |
| _____ jumps repeatedly | 1 2 3 4 5 |
| _____ needs to swing frequently | 1 2 3 4 5 |
| _____ likes to "crash" into furniture or people | 1 2 3 4 5 |
| _____ takes others by the wrist to use their hands to open doors, get objects, turn on TV, operate toys, etc. | 1 2 3 4 5 |

ANY OTHER MOVEMENT ISSUES:-----

LANGUAGE

- _____ started talking when younger but stopped or lost skills 1 2 3 4 5
- _____ needs instructions repeated several times 1 2 3 4 5
- _____ displays below average performance in one or more areas of academics 1 2 3 4 5
- _____ difficulty with phonics 1 2 3 4 5
- _____ problems recalling what was heard last week, month, year 1 2 3 4 5
- _____ lacks motivation to learn 1 2 3 4 5
- _____ short attention span 1 2 3 4 5
- _____ speaks only on command 1 2 3 4 5
- _____ does not follow directions 1 2 3 4 5
- _____ comes to situations “without a clue” 1 2 3 4 5
- _____ seems not to generalize from past experiences 1 2 3 4 5
- _____ voice lacks intonation, resonance or tone 1 2 3 4 5
- _____ sings “off key” or not at all 1 2 3 4 5
- _____ says “huh” and “what?” frequently 1 2 3 4 5
- _____ relies on visual cues such as pictures, print, facial expressions 1 2 3 4 5
- _____ easily distracted by noise 1 2 3 4 5
- _____ daydreams 1 2 3 4 5
- _____ slowed or delayed response to verbal input 1 2 3 4 5
- _____ poor comprehension 1 2 3 4 5
- _____ learns poorly through verbal instruction 1 2 3 4 5
- _____ learns poorly through visual instruction 1 2 3 4 5
- _____ “hums” or makes noises to himself 1 2 3 4 5

----- frequently gives off or inappropriate responses	1 2 3 4 5
----- says words or sentences that don't make sense	1 2 3 4 5
----- poor organizational skills	1 2 3 4 5
----- confuses sounds in spelling or writing	1 2 3 4 5
----- seeks out or fixates on certain sounds	1 2 3 4 5
----- avoids social contact	1 2 3 4 5
----- difficulty finding words to express self	1 2 3 4 5
----- when in a crowd, does not know speech is directed toward him/her	1 2 3 4 5
----- only likes books with repetitive story lines	1 2 3 4 5
----- distorted speech (jargon)	1 2 3 4 5
----- makes extreme high pitched or low pitched sounds	1 2 3 4 5
----- does not know appropriate use of toys	1 2 3 4 5
----- repeats same question over and over without listening to answer	1 2 3 4 5
----- withdraws from family gatherings or dinners	1 2 3 4 5
----- does not play well with other children	1 2 3 4 5
----- memory problems	1 2 3 4 5
----- exceptionally good memory	1 2 3 4 5
----- talks to self	1 2 3 4 5
----- difficulty with spelling	1 2 3 4 5
----- difficulty with reading	1 2 3 4 5
----- difficulty with sound articulation	1 2 3 4 5
----- difficulty with hand writing	1 2 3 4 5
----- can't find things	1 2 3 4 5
----- memorizes words to songs, stories or movies	1 2 3 4 5
----- often seems to be in another world	1 2 3 4 5
----- speaks too fast	1 2 3 4 5
----- acts out or imitates TV characters or videos	1 2 3 4 5
----- delayed response to questions	1 2 3 4 5

ANY OTHER LANGUAGE ISSUES:-----

SOUND SENSITIVITY

Holds hands over ears or complains about:-----

(blowers, vacuum, drill, smoke alarm fire drill bell, airplane or car noise, electric clippers, fireworks, music, sings, baby crying, thunder, blow dryer)

Dislikes the sound of:-----

(running water, toilet flushing, car radio, blender, mixer, lawn mower, elevators, church choir, bees, restaurants, dogs barking)

- | | |
|---|-----------|
| _____ likes the sound of music | 1 2 3 4 5 |
| _____ does not like car windows down | 1 2 3 4 5 |
| _____ does not like to have hair cut | 1 2 3 4 5 |
| _____ puts ears next to TV speaker | 1 2 3 4 5 |
| _____ cannot concentrate around noise or crowds | 1 2 3 4 5 |
| _____ does not like large stores or malls | 1 2 3 4 5 |
| _____ hears noises all night | 1 2 3 4 5 |
| _____ when around certain sounds says "off" or "no" | 1 2 3 4 5 |
| _____ does not respond when name is called | 1 2 3 4 5 |
| _____ startles easily to sounds/noises | 1 2 3 4 5 |
| _____ hears planes, cars, etc. before others | 1 2 3 4 5 |
| _____ turns music or TV loud | 1 2 3 4 5 |
| _____ upset by storms/ wind/ thunder | 1 2 3 4 5 |
| _____ wants to wear headphones | 1 2 3 4 5 |
| _____ refuses to wear headphones | 1 2 3 4 5 |
| _____ turns car radio off | 1 2 3 4 5 |

Other sound sensitivity:-----

Sensitive to: Smell_____ Taste_____
Touch_____ Visual input_____
Temperature _____ Light_____

SLEEP HABITS:

- _____ poor sleeping habits 1 2 3 4 5
_____ wakes from sleep because of sounds 1 2 3 4 5
_____ spends time in bed under the covers 1 2 3 4 5
_____ has nightmares 1 2 3 4 5
_____ needs regular "quiet time" in order to sleep 1 2 3 4 5
_____ takes long naps 1 2 3 4 5
_____ stopped naps early 1 2 3 4 5
_____ hard to get to sleep/bed at night 1 2 3 4 5
_____ light sleeper 1 2 3 4 5
_____ goes to sleep with music 1 2 3 4 5
_____ snores or talks in sleep 1 2 3 4 5
_____ seems tired all the time 1 2 3 4 5
_____ has plenty of energy with little sleep 1 2 3 4 5
_____ dark circles under eyes 1 2 3 4 5

Any other sleep issues:_____

EATING/ORAL MOTOR HABITS:

- _____ likes to eat alone 1 2 3 4 5
_____ picky eater 1 2 3 4 5
_____ eats large amounts of food 1 2 3 4 5
_____ doesn't seem to recognize he/she's full 1 2 3 4 5
_____ stuffs too much food in mouth 1 2 3 4 5
_____ grinds teeth day___ night___ 1 2 3 4 5
_____ chews on toys, clothing or other non-food items 1 2 3 4 5
_____ difficulty with foods that need chewed 1 2 3 4 5

- food texture preferences soft----- crunchy----- 1 2 3 4 5
- calmed by chewing gum 1 2 3 4 5
- low oral tone/drools 1 2 3 4 5
- bites fingernails 1 2 3 4 5
- gags/ chokes on some foods (which ones?-----) 1 2 3 4 5
- difficulty weaning or learning to use cup or straw 1 2 3 4 5

Any other feeding/oral motor issues:-----

TACTILE SENSITIVITY:

- only wears certain clothes 1 2 3 4 5
- wants clothing tags removed 1 2 3 4 5
- has a fabric preference (what?-----) 1 2 3 4 5
- refuses to wear clothes/ shoes at home 1 2 3 4 5
- must always have an object in his/her hand 1 2 3 4 5
- gets under pillows or blankets 1 2 3 4 5
- high pain tolerance 1 2 3 4 5
- likes to touch others hair, faces, etc. 1 2 3 4 5
- examines surfaces with fingers 1 2 3 4 5
- does not like new clothing 1 2 3 4 5
- only wears short sleeved shirts 1 2 3 4 5
- repelled by some textures (what?-----) 1 2 3 4 5
- self-stimulates (how?-----) 1 2 3 4 5

OTHER TACTILE/TOUCH ISSUES:-----

SELF HELP

- age of toilet training 1 2 3 4 5
- not toilet trained -----
- needs help dressing 1 2 3 4 5
- needs help eating 1 2 3 4 5

_____ cannot blow nose 1 2 3 4 5

Other self-help issues:-----

HABITS/BEHAVIORS:

_____ difficult to sedate 1 2 3 4 5

_____ dislikes school 1 2 3 4 5

_____ aggressive to peers or adults 1 2 3 4 5

_____ does not get along well with other children 1 2 3 4 5

_____ likes to spin things 1 2 3 4 5

_____ obsessed with specific kinds of toys/objects (wheels on cars, etc) 1 2 3 4 5

_____ insists on being in control 1 2 3 4 5

_____ wants demands met quickly 1 2 3 4 5

_____ screams but does not cry 1 2 3 4 5

_____ quick to anger 1 2 3 4 5

_____ slow to calm down from tantrums 1 2 3 4 5

_____ difficulty with public bathrooms 1 2 3 4 5

_____ not able to eat in restaurants 1 2 3 4 5

_____ non-compliant most of the time 1 2 3 4 5

_____ likes to play alone 1 2 3 4 5

_____ hits objects to make noise 1 2 3 4 5

_____ likes vibration 1 2 3 4 5

_____ strong willed 1 2 3 4 5

_____ routine very important/becomes upset if routine is changed 1 2 3 4 5

_____ lines toys up 1 2 3 4 5

_____ doesn't make eye contact 1 2 3 4 5

_____ doesn't seem to know how to socialize 1 2 3 4 5

_____ runs/spins self in circles 1 2 3 4 5

_____ climbs on furniture/people 1 2 3 4 5

----- has obsessive behaviors (what?-----)	1 2 3 4 5
----- gets "hooked" or fixated on one topic	1 2 3 4 5
----- hurts siblings or pets	1 2 3 4 5
----- only makes eye contact with family members	1 2 3 4 5
----- no concept of time	1 2 3 4 5
----- rubs hands together over and over	1 2 3 4 5
----- prefers to watch TV/video than to play with others	1 2 3 4 5
----- difficulty transitioning from one activity/place to another	1 2 3 4 5
----- not aware of surroundings	1 2 3 4 5
----- does not like to wait or be told "no"	1 2 3 4 5
----- does not recognize fearful situations	1 2 3 4 5
----- does dangerous things	1 2 3 4 5
----- runs away from parents or leaves house when not watched	1 2 3 4 5
----- extreme fears of people, places, animals, etc. (what?-----)	1 2 3 4 5

BEHAVIOR YOU LIKE ABOUT YOUR CHILD-----

BEHAVIOR YOU WISH THEY'D STOP-----

DOES YOUR CHILD EXHIBIT ANY UNUSUAL DEGREE OF SKILL IN A PARTICULAR AREA?
 (puzzles, reading, remembering dates/times, motor skills, perfect pitch, math)

WHAT DO YOU FEEL ARE YOUR CHILD'S STRENGTHS:-----

WHAT DO YOU FEEL ARE YOUR CHILD'S NEEDS:-----

PLEASE LIST ANYTHING ELSE YOU'D LIKE ME TO KNOW ABOUT YOU/YOUR CHILD!

THANKS FOR YOUR TIME! PLEASE RETURN TO: Becky Welker