THE LISTENING FITNESS™ PROGRAM
PERSONAL HISTORY FOR CHILDREN

(To be completed by parent/guardian)

Dear parent,

This questionnaire is designed to gather the information we need for the Assessment of your child for a Listening Fitness Program. We are interested in knowing both your child's strengths and difficulties as well as the context in which he/she experiences them.

We appreciate the time you will spend in completing this personal history. In the past, many parents have commented that completion of this questionnaire has shed light on the understanding of their child. We hope this will also be your experience.

Thank you for your cooperation.

Family name:_____ Child's name:_____

Address:_____ Date of Birth:_____

_____ Age:_____ Grade:_____

_____

Phone # Home: (___)_____ Completed by:_____

Work: (___)_____ Completed on (date): _____

How did you find out about the Listening FitnessProgram? _____

Family

	Name	Age	Sex	Adopted	Education	Occupation	
Father:	_____	____		Yes No	_____	_____	R/L
Mother:	_____	____		Yes No	_____	_____	R/L
Children:	_____	____	____	Yes No	_____	_____	R/L
	_____	____	____	Yes No	_____	_____	R/L
	_____	____	____	Yes No	_____	_____	R/L
	_____	____	____	Yes No	_____	_____	R/L

*R/L=Right or Left handed

Marital Status of parents: Married/Common Law__Separated__Divorced__Other__

Is your marital situation stable and positive at this time?_____

What language(s) is (are) spoken at home? _____

Your Child

Has your child been diagnosed as having a specific disorder or illness?_____

_____

Can a similar problem be traced on either side of the natural parent's family?_____

_____

Has he/she received any remedial help from special interventions or therapies?_____

_____

Have there been any specific events or traumas linked with the onset of the child's difficulties,

...or in the course of your child's development?_____

_____

How would you describe your child's social adjustment?

With peers:_____

With adults:_____

Developmental history

During **pregnancy**, what language(s) was spoken by the mother? _____

Were there any complications? (Shock / Emotional Stress / Loss of loved one / Accident / Health problems / Fatigue / Confined to bed / Other) _____

_____

During **labour and delivery**, were there any complications? (Length of term / Abnormal delivery position / Forceps used / Ceasarian birth / Birth weight / Required oxygen / Required incubator / Had jaundice or other health problems / Other)_____

_____

Going back to your child's **first two years of life**, comment on any difficulties your baby might have had concerning breast feeding, feeding, sleeping, specific health problems, thumb sucking, level of energy, etc._____

_____

Were there any extended separations from the parents? Yes____ No____ If yes, when and for how long:_____

How would you describe your child's **sensory-motor development**?

Normal ___ Delayed ___ Advanced ____ Describe any difficulties or peculiarity related to motor development?_____

Were there any complications with toilet training?_____

At what age did the child crawl? _____ walk? _____ develop hand preference? _____

Did he/she have a fear of being rocked or swung? _____

Did he/she dislike nails or hair cuts, brushing teeth or being touched or hugged?_____

_____

How would you describe your child's **speech and language development**?

Normal_____ Delayed _____ Advanced _____ Describe any speech and language related difficulties or peculiarity:_____

_____

Did he/she experience any **problems with eye contact and/or eyesight and/or vision**?

Did he/she experience any **problems with his/her ears**? (operations, fluid, need for hearing aids, etc) _____

What about ear infections? Seldom _____ Sometimes _____ Often _____
(Less than 5) *(Between 5 and 10)* *(More than 10)*

Mild_____ Moderate_____ Severe_____

More specifically, between the age of _____and _____

Health

How would you describe your child's health since age two? _____

_____

_____

Asthma____ Bronchitis____ Skin problems____ Gastro-intestinal problems____

Convulsions____ Epilepsy____ Operations____ Injuries____ Headaches____ Nightmares____

Fitful sleep_____ Bedwetting____ Nail biting_____ Teethgrinding___ Snoring____

Is your child prone to allergies or food/environmental sensitivities?_____

Is he/she on a special diet?_____

Does he/she have any food addictions? _____Since when and what kind?_____

Is he/she in good general health at the present time? _____

Is he/she taking any prescribed medication? _____ Since when? _____

School history

If applicable, how old was your child when he/she started to go to day care? _____

How was your child's adaptation to the first days of separation?

Mostly positive____ Mixed____Mostly negative____

Give us information about any ***personal, social or academic*** **difficulties** your child encountered in school beginning with the earliest experience.

Kindergarten: _____

_____

Grade 1-3: _____

_____

Grade 4-6: _____

_____

Intermediate and High School_____

_____

How many students are there in your child's classroom?_____

How would you qualify your child's **interest, motivation and attitude** toward school?_____

_____

Has your child received help from the **Special Education** system?_____

_____

Are you satisfied with your child's school placement?_____

_____

Lifestyle

What type of person is he/she?

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____
_____	_____

How many hours per week does your child spend watching television? _____

How many hours per week does your child play computer or Nintendo games? _____

What kind of **interests and activities** does your child have? (Hobbies, sports, games, etc.) Please list them according to the child's greatest to least interest.

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Goals of the Listening Fitness Program

Please put a number (1, 2 or 3) beside the description that corresponds with your goals for having your child in the Listening Fitness Program in order of importance. Do not hesitate to check more than one item with the same number.

1=most important and main reason for starting program 2=area of secondary concern 3=area in which change would be welcome but not crucial

____Regulation of energy (e.g overactive/underactive, fatigue)

____Attention, concentration, ability to stay on task

____Motor skills, balance, coordination

____Listening skills (e.g. comprehension, interpretation of messages)

____Speech (e.g. verbal communication)

____Organizational skills (e.g. study habits, tidiness)

____Maturity (e.g. dependence, childishness)

____Motivation at school

____Motivation in other situations (e.g. socialization, playfulness)

____Flexibility (e.g. greater curiosity, welcoming changes, less stubbornness)

____Social behavior (e.g. moodiness, shyness, relating to others)

____Academic/learning skills (e.g. reading, spelling, writing, math, memory)

____Musical skills (e.g. singing, playing an instrument)

____Second language acquisition

____General well-being (e.g. less anxiety, greater self image)

____Other (Specify) _____

Additional comments: _____

_____

Now, we would like you to fill out the Listening Questionnaire which lists out numerous listening-related behaviours your child might or might not have difficulties with.

THANK YOU

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