Name:_____ DOB:_____

Sensory History

General

How would you describe your child?

_____

_____

_____

_____

Does your child have difficulty transitioning between activities, places, people? YES NO
Is your child typically difficult to calm? YES NO
What strategies seem to be most effective for transitions and/or calming?

_____

_____

_____

Does your child have difficulty getting to sleep/staying asleep/waking? YES NO
Describe your child's bedtime routine:

_____

_____

Does your child nap?
How many total hours of sleep does your child average in a 24 hour period? _____

Vestibular

Does your child prop his head or lean on a surface when seated or standing?

	YES	NO
Does your child prefer sitting on the floor?	YES	NO
Does your child stand with a wide base?	YES	NO
Do his trunk and shoulder movements seem stiff or rigid?	YES	NO
Does the child dislike having his feet off the floor?	YES	NO
Does the child like swinging and climbing at the playground?	YES	NO
Does the child resist being moved by others?	YES	NO
Does the child avoid crossing midline (reaching across his body?)	YES	NO
Does your child fear climbing in/out of bed or on/off furniture?	YES	NO
Does the child seek movement, such as spinning or rocking?	YES	NO
Does the child get car sick easily?	YES	NO
Get nauseous from movement experiences?	YES	NO

Tactile

Is your child particular about what he wears?	YES	NO
Does your child avoid touching certain textures (sand, glue, paint, etc.)?	YES	NO
Is your child a picky eater?	YES	NO
Does your child like hiding in small places?	YES	NO
Does your child like it when others touch him/her?	YES	NO
Does your child seem to touch everything?	YES	NO
Does your child put a lot of non-food items in his mouth?	YES	NO
Does your child insist on always holding something in his hand?	YES	NO
Does your child avoid crowds?	YES	NO
Is your child unaware of cuts/bruises/minor injuries?	YES	NO
Does you child notice when clothes are twisted or look messy?	YES	NO
Does your child tolerate bathing and grooming activities?	YES	NO

Proprioception

Does your child seem to use too much force with toys/objects?	YES	NO
Does your child walk up on tiptoes a lot?	YES	NO
Does your child seem to have a weak grasp?	YES	NO
Does your child seem clumsy or awkward when moving?	YES	NO
Is your child always tripping over objects or running into things?	YES	NO

Visual/auditory

Does your child avoid eye contact?	YES	NO
Does your child visually engage with people and toys?	YES	NO
Is he/she sensitive to light?	YES	NO
Does he/she get upset about unexpected or loud noises? (vacuum, lawnmower, etc.)	YES	NO
Does your child like to make loud noises?	YES	NO
Does your child startle easily?	YES	NO

Other comments:

_____

_____

_____

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