

Child's Name: _____

Sensory Checklist

Place a check in the appropriate column. Feel free to make other comments you feel are pertinent to your child's sensory development.

Tactile Sensation

Does your child:

1. Object to being touched? Yes No
2. Dislike being cuddled? Yes No
3. Was your child irritable in infancy, particularly when held? Yes No
4. Prefer to touch rather than be touched? Yes No
5. Dislike having hair and/or face washed? Yes No
6. Prefer certain textures of clothing? Yes No
7. Avoid certain textures of food? Yes No
8. Isolate self from other children? Yes No
9. Frequently bump or push other children? Yes No

Comments: _____

Vestibular Sensation

Does your child:

1. Seem fearful in space? (ie going up and down stairs, riding teeter-totter) Yes No
2. Appear clumsy, often bumping into things and/or falling down? Yes No
3. Prefer fast-moving, spinning carnival rides? Yes No
4. Appear to be in "perpetual motion"/ difficulty sitting still or focusing Yes No

Comments: _____

Modulation

Does your child:

1. Have difficulty with transitions? Yes No
2. Shut down or have meltdowns? Yes No
3. Seem to be emotionally "up and down"? Yes No
4. Have a low frustration tolerance? Yes No
5. Rock, bang head, hit easily when frustrated? Yes No

Coordination

Does your child:

1. Manipulate small objects easily? Yes No
2. Seem accident prone? (frequent scrapes/bruises) Yes No
3. Eat in a sloppy manner? Yes No
4. Have difficulty with pencil activities? Yes No
5. Have difficulty dressing and/or fastening clothes? Yes No

Comments: _____

Auditory Sensation

Does your child:

1. Seem overly sensitive to sound? Yes No
2. Miss some sounds? Yes No
3. Seem confused about the direction of sounds? Yes No
4. Like to make loud noises? Yes No
5. Have a diagnosed hearing loss? Yes No

Comments: _____

Muscle Tone:

Does your child:

1. Have any diagnosed muscle pathology (ie, spasticity, flaccidity, rigidity, etc)? Yes No
2. Seem weaker or stronger than normal? Yes No
3. Have a weak grasp? Yes No
4. Tire easily? Yes No

Comments: _____

Visual Sensation

Does your child:

1. Have a diagnosed visual defect? Yes No
2. Have difficulty eye-tracking? Yes No
3. Make reversals when copying? Yes No
4. Have difficulty discriminating colors, shapes? Yes No
5. Appear sensitive to light? Yes No
6. Resist having vision occluded? Yes No
7. Become excited when confronted with a variety of visual stimuli? Yes No

Comments: _____

(Adapted from Pat Wilbarger, OTR/L
Revised by Robyn Colley, OTR/L)

Sensory History 011603