Thera-Peds
Pediatric Therapy

Sensory History Checklist

Child's Name: _____ Date Form Completed: _____
Date of Birth: _____ Person Completing Form: _____

Instructions: Please check the response that best describes your child's behavior. Add any additional comments in the space after each category. Please comment if your child demonstrated the behavior in the past, but does not do so at this time. If you are unable to comment because you have not observed the behavior, or feel that it is not applicable to your child, please draw a line through the response (----). Please, do not leave spaces blank. Use the following key to determine your response.

Key to Responses:

1.Always: when presented with the opportunity, child responds in this manner 100% of the time
2. Frequently: when presented with the opportunity, child responds in this manner 50-75% of the time
3. Occasionally: when presented with the opportunity, child usually does not respond in this manner, only 25-50% of the time
4. Seldom: when presented with the opportunity, child seldom responds in this fashion, less than 25% of the time
5. Past: in the past, child responded in this fashion, not presently
6. Never: when presented with the opportunity, child never responds in this fashion, 0% of the time

Auditory	Always	Freq.	Occ'ly	Seldom	Past	Never
1. Responds negatively to unexpected loud noises (vacuum cleaner, dog barking, hair dryer)						
2. Appears not to hear what you say						
3. Doesn't respond when name is called						
4. Seems oblivious within an active environment						
5. Holds hands over ears						
6. Has trouble completing tasks with background noise (radio)						

Comments: _____

Visual	Always	Freq.	Occ'ly	Seldom	Past	Never
1. Looks away from tasks to notice all actions in the room						
2. Hesitating going up or down curbs or steps						
3. Gets lost easily						
4. Stares intensely at objects or people						
5. Avoids eye contact						
6. Doesn't notice when people come into the room						
7. Is bothered by bright lights after others have adapted to lights						
8. Writing is illegible						

Comments:

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Gustatory (taste, smell)	Always	Freq.	Occ'ly	Seldom	Past	Never
1. Deliberately smells objects						
2. Avoids certain tastes/smells that are typically part of a child's diet						
3. Limits self to particular foods, textures, temperatures (List)						
4. Shows strong preference for certain tastes						
5. Chews/licks on non-food objects						
6. Craves certain foods						
7. Gags easily on food textures, food utensils in mouth						

Comments: _____

Movement (vestibular)	Always	Freq.	Occ'ly	Seldom	Past	Never
1. Dislikes beings held where head upside down (somersaults) or roughhousing						
2. Seeks all kinds of movement, and this interferes with daily routines						
3. Avoids climbing, jumping or bumpy /uneven ground						
4. Twirls/spins self frequently throughout day						
5. Becomes overly excited after a movement activity						
6.Poor endurance, tires easily						
7. Avoids playground equipment or moving toys						
8. Takes movement or climbing risks during play that compromise personal safety						
9. Rocks in desk/chair/on floor						
10. Prefers sedentary activities						

Comments: _____

Body Position (proprioception)	Always	Freq.	Occ'ly	Seldom	Past	Never
1. Seeks opportunity to fall without regard for personal safety						
2. Hangs on other people, furniture, objects, even in familiar situation (clingy)						
3. Seems to have weak muscles						
4. Tires easily, especially when standing or holding a certain body position						
5. Locks joints (elbows, knees) for stability						

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6. Walks on toes						
7. Props to support self						
8. Runs into things, accidentally and/or on purpose						

Comments:_____

Touch (tactile)	**Always**	**Freq.**	**Occ'ly**	**Seldom**	**Past**	**Never**
1. Avoids getting hands "messy" (in paste, sand, finger painting, glue, tape)						
2. Expresses distress in grooming (hair cutting, face washing, fingernail cutting)						
3. Sensitive to certain fabrics; avoids wearing clothes made of them, particular about certain clothes or bed sheets						
4. Touches people or objects, sometimes to the point of irritation						
5.Reacts emotionally or aggressively to touch						
6. Displays unusual need for touching certain toys, surfaces or textures						
7. Mouths objects frequently (pencil, hands)						
8. Doesn't seem to notice when someone touches arm or back						
9. Becomes irritated by shoes or socks						

Comments:_____

Emotional/Social	**Always**	**Freq.**	**Occ'ly**	**Seldom**	**Past**	**Never**
1. Needs more protection from life than other children						
2. Has trouble "growing up"						
3. Overly affectionate with others						
4. Displays emotional outbursts when unsuccessful at a task						
5. Has difficulty tolerating changes in routines						
6. Doesn't express emotions						
7. Doesn't perceive body language or facial expressions						
8. Overly serious						
9. Has difficulty making friends						
10. Enjoys other children of similar age						
11. Seems accident prone						
12. Uses inefficient way of doing things						

Comments:

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Activity Level	Always	Freq.	Occ'ly	Seldom	Past	Never
1. Always "on the go"						
2. Prefers quiet sedentary play (watching tv, reading a book, computer)						
3. Avoids quiet play activities						
4. Jumps from one activity to another so frequently it interferes with play						
5. Difficulty paying attention						

Comments: _____

Are you concerned with any specific behaviors currently, or in the past, that you would like to address or comment about? _____

What type of sensory stimulation does your child prefer? _____

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