SENSORY PROCESSING AND FUNCTIONAL SKILLS CHECKLIST

Child's name: _____ Completed by: _____

Date of Birth: _____ Date completed: _____

Please note whether each of the items listed affects your child "always," "sometimes," or "never" using check marks. For each item marked "always" or "sometimes," rank how concerned your family is about this using the following scale: **(1) = a little, (2) = moderately, (3) = very much**. Please make notes in the comment box about how the items are affecting your child or your family.

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Oral Sensory System					
Deliberately smells objects				1 2 3	
Is overly sensitive to odors				1 2 3	
Licks, sucks, chews non-food items				1 2 3	
Chews on shirt collar, sleeve, etc.				1 2 3	
Craves intense flavors (sour, spicy)				1 2 3	
Bites self, others, objects				1 2 3	
Is a "picky eater" (eats few to no vegetables, fruits, proteins)				1 2 3	
Refuses all but a few food choices				1 2 3	
Is a messy eater				1 2 3	
Stuffs food into mouth				1 2 3	
Is unaware of food left on his lips				1 2 3	

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Tactile System					
Has decreased awareness of pain/temperature (does not register)				1 2 3	
Seeks being wrapped tightly in sheets/blankets or seeks tight spaces				1 2 3	
Is not aware of personal space				1 2 3	
Tends to not notice if hands or face are messy				1 2 3	
Constantly touches objects/people				1 2 3	
Becomes irritated by tags in clothing				1 2 3	
Becomes irritated if clothing is twisted				1 2 3	
Has a negative reaction to or refuses to wear certain fabrics				1 2 3	
Refuses to wear socks and/or shoes				1 2 3	
Dislikes being hugged or held/cuddled				1 2 3	
Reacts negatively to touch				1 2 3	
Resists grooming activities such as hair washing, hair cutting, tooth brushing, nail trimming (Circle all that apply)				1 2 3	
Avoids getting hands messy				1 2 3	
Becomes upset it face is messy				1 2 3	
Refuses to walk barefoot on various textures (e.g., grass, tile, carpet)				1 2 3	

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Vestibular System					
Is always "on the go"				1 2 3	
Likes being tipped upside down or lifted overhead				1 2 3	
Jumps on the bed or other surfaces				1 2 3	
Climbs at the risk of his/her own safety				1 2 3	
Rocks body front/back or side-to-side				1 2 3	
Seeks movement that interferes with daily activities				1 2 3	
Hesitates to climb, swing, or avoids other playground equipment				1 2 3	
Becomes upset when upside down or when head is tipped back (e.g., with a diaper change or hair washing)				1 2 3	
Becomes anxious when feet leave the ground (picked up/tossed in the air)				1 2 3	
Has poor balance				1 2 3	
Becomes car sick easily/has motion sickness				1 2 3	
Proprioceptive System					
Seems to be aggressive/rough during play				1 2 3	
Craves rough play				1 2 3	
Crashes into people/objects intentionally				1 2 3	
Tends to break objects when playing with them; uses an inappropriate amount of force				1 2 3	

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Proprioceptive System					
Uses too much or too little force (Please circle)				1 2 3	
Bumps into things frequently				1 2 3	
Has difficulty with fine motor or gross motor tasks				1 2 3	
Auditory System					
Appears to be ignoring you but hearing is fine				1 2 3	
Covers ears when hearing or anticipating certain sounds				1 2 3	
Responds negatively to or becomes upset with sounds such as a vacuum, toilet, lawn mower, loud truck, dog barking, etc.				1 2 3	
Has difficulty following multi-step directions				1 2 3	
Uses a voice volume too soft or too loud (Please circle)				1 2 3	
Is distracted in noisy environments				1 2 3	
Hears sounds that others tend not to hear				1 2 3	
Confuses similar sounding words or mispronounces words				1 2 3	
Asks you to repeat what you have said				1 2 3	
Has/Had delayed or immature speech patterns				1 2 3	

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Visual System					
Seeks out visual stimulation (e.g., watches spinning objects, intensely stares at objects)				1 2 3	
Has difficulty with reading, writing, spelling, and/or math (please circle all that apply)				1 2 3	
Tends to reverse letters				1 2 3	
Has difficulty finding objects in a complex background (e.g., locating item in closet, fridge, or toy box)				1 2 3	
Has difficulty completing puzzles				1 2 3	
Demonstrates poor depth perception (e.g., stepping off a curb, walking down stairs)				1 2 3	
Has poor eye contact				1 2 3	
Dislikes bright lights/squints or covers eyes				1 2 3	
Becomes overstimulated by busy visual environments				1 2 3	
Multiple Sensory Systems					
Appears to not notice others/things occurring in the environment				1 2 3	
Has difficulty regulating sleep/wake cycle (e.g., settling for sleep, staying asleep, waking without irritability)				1 2 3	
Has low muscle tone or is considered a "floppy kid"				1 2 3	
Fatigues easily, seems weak, or has poor endurance				1 2 3	
Has difficulty standing in lines				1 2 3	
Becomes easily distracted by things occuring in the environment				1 2 3	

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Multiple Sensory Systems					
Moves in quick bursts, rather than slow, sustained movements				1 2 3	
Walks on toes				1 2 3	
Is clumsy or moves awkwardly				1 2 3	
Is accident-prone				1 2 3	
Avoids gross motor movement				1 2 3	
Tends to prop head on hand				1 2 3	
Tends to slump in chair				1 2 3	
Prefers sedentary play				1 2 3	
Tends to be wiggly in a chair				1 2 3	
Activities of Daily Living					
Requires assistance to brush teeth				1 2 3	
Requires assistance to brush hair				1 2 3	
Requires assistance to bathe self				1 2 3	
Has bowel or bladder accidents				1 2 3	
Requires assistance with toileting				1 2 3	
Requires assistance to dress or undress				1 2 3	

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Activities of Daily Living					
Has difficulty with fasteners (e.g., buttons, zippers, ties)				1 2 3	
Has difficulty with clothing orientation (puts clothing on backward or inside out)				1 2 3	
Requires assistance to fall asleep or stay asleep				1 2 3	
Has difficulty using utensils				1 2 3	
Refuses to eat a variety of nutritious foods				1 2 3	
Chokes, coughs, or gags while eating				1 2 3	
Social Skills					
Needs prompts to initiate play with peers				1 2 3	
Uses poor eye contact				1 2 3	
Lacks pretend play skills				1 2 3	
Demonstrates poor awareness of personal space				1 2 3	
Has difficulty making or keeping friends				1 2 3	
Has difficulty interacting with same-aged peers				1 2 3	
Hits, kicks, or bites peers				1 2 3	
Seeks out independent play				1 2 3	

My Child…	Always	Sometimes	Never	Level of Concern	Comments (Please describe any behavioral responses you observe or additional information)
Self-Management and Emotional Regulation					
Has difficulty with transitions (moving between activities, places, or new things)				1 2 3	
Has poor safety awareness				1 2 3	
Lacks coping skills				1 2 3	
Has meltdowns (Please describe your child's meltdowns in the comment section. Feel free to attach an additional page.)				1 2 3	
Engages in self-injurious behaviors (biting self, banging head, etc.)				1 2 3	

Please use this space for additional comments. It is helpful for us to hear how your concerns about your child impact your family:
(Please feel free to attach additional pages, if needed.)

_____
_____
_____
_____
_____
_____
_____

Please circle the following environments in which your child or family's ability to participate is impacted.

Home	**School**	**Performance events**	**Movie theater**	**Other:_____**
Restaurants	**Playgrounds**	**Grocery Store**	**Homes of family/friends**	
Place of worship	**Community Center**	**Retail stores/mall**	**Sporting events**	