HOW DO I KNOW?

DOES MY CHILD HAVE A SENSORY DISORDER?

What is Sensory Integration?

The normal process of taking in information from within the body and from the environment through the senses to plan and execute adaptive responses to different challenges in order to learn and function smoothly in daily life. Our senses work together to give us a reliable picture of the world and our place in it, to give us complete understanding of who we are, where we are, and what is happening around us.

What is a Sensory Disorder?

The term "Sensory Disorder" covers a broad spectrum of issues that effect a child's reaction to sensations and situations he finds challenging, his alertness and attention span, motor skills, feeding, and ability to transistion from one activity or situation to another. A child with a Sensory Disorder may exhibit sensory seeking and sensory avoiding behaviors, find transistions between activities to be stressful, be unable to tolerate sensations or situations he finds to be challenging, or have difficulties with feeding.

How do I know if my child has a Sensory Disorder?

The Occupational Therapy Sensory Questionnaire below can help us determine if your child has a sensory disorder, and whether Sensory Integration Program or other Occupational Therapy services may be of benefit to him or her.

Occupational Therapy Sensory Questionnaire

Child's Name:

Date of Birth (MM/DD/YYYY):

Diagnosis:

Program(s) Enrolled in:

Seizure Disorder? ☐ Yes ☐ No If yes, is it controlled?

Hearing Difficulties? ☐ Yes ☐ No If yes, provide details.

Visual Difficulties? ☐ Yes ☐ No If yes, provide details.

Date of Assessment (MM/DD/YYYY):

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Tactile Assessment

Dressing	Yes	No
Tolerates layers of clothing.		
Pushes up or pushes down pants legs, sleeves, and shirts.		
Strips off clothing.		
Refuses to undress.		
Frequently adjusts clothing as if it binds or is uncomfortable.		
Wraps self in clothing or bedding.		
Insists on something wrapped around wrist, arm or finger.		
Avoids/irritated by certain clothing textures.		
Indicates distress when barefoot.		
Insists on being barefoot.		

Comments:

Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Other Activities of Daily Living	Yes	No
Spits out or rejects certain food textures.		
Resists grooming. (Please check which) ☐ Face Washing ☐ Shaving ☐ Hair Combing ☐ Hair Cutting ☐ Tooth Brushing ☐ Nail Trimming ☐ Bathing ☐ Hair Washing		

Comments:

Personal Space	Yes	No
Insists on large personal space.		
Prefers to be in corner, under table, behind furniture.		

Comments:

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:	
Social	**Yes**	**No**
Looks fearful, angry, or uncomfortable when approached or touched.		
Withdraws or hits when peers reach toward client or are nearby.		
Withdraws or hits when staff reach toward client or are nearby.		
Rubs spot after being touched.		
Exhibits clingy behavior.		
Tries to handle or touch everything/everyone.		
Avoids palm/hand contact with objects or people.		

Comments:

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Self-Stimulatory Behaviors	Yes	No
Engages in persistent hand to mouth activity.		
Mouths objects or clothing.		
Rubs or plays with spit/saliva.		
Persistently has hand in pants or pants pocket.		
Sits on hands/feet.		
Pushes or rubs body against objects/walls/people.		
Insists on holding an object in hand(s).		
Rubs fingers(s) against hands or other fingers.		
Comments:		

Self-Injurious Behaviors	Yes	No
Scratches.		
Pinches.		
Rubs.		
Hits/Slaps.		
Pulls Hair.		
Bites hand/wrist/arm.		
Comments:		

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Vestibular Assessment

Muscle Tone
(problem not due to neuromuscular diagnosis)

	Yes	No
Needs assistance when moving from sitting, lying, or standing.		
Uses arms to assist self when moving from sitting, lying, or standing.		
Props head or leans when sitting or standing.		
Collapses onto furniture.		

Comments:

Equilibrium Responses

	Yes	No
Loses balance easily.		
Trips or falls often.		
Holds onto staff, railing, or wall.		
Has slow or no protective response.		
Persistently sits on floor.		

Comments:

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Posture and Movement	**Yes**	**No**
Displays S curve posture.		
Holds arms flexed, adducted and internally rotated.		
Uses shuffling gate or poor heel-toe pattern.		
Displays wide based stance.		
Uses side-to-side gait.		
Has head-neck-shoulder rigidity.		
Resists being moved by others.		
Avoids/needs assistance with overhead reach.		
Demonstrates poor postural background movements.		
Resists participating in movement activities.		

Comments:

Bilateral Coordination	**Yes**	**No**
Uses mainly one hand at a time in activities requiring two.		
Avoids midline crossing.		
Timing uneven in 2-handed or 2-footed movements.		

Comments:

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Spatial Perception	Yes	No
Bumps into objects.		
Has difficulty walking around furniture or people.		
Has difficulty going through doorways.		
Descends or ascends stairs, or ramps without alternating feet.		
Exhibits hesitancy at stairs or ramps.		

Comments:

Emotional Expression	Yes	No
Displays gravitational insecurity.		
Tenses or becomes irritable when moved.		
Becomes upset at changes in room arrangement.		
Looks anxious when moving from place to place.		

Comments:

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:	
Self-Stimulatory Behaviors	**Yes**	**No**
Rocks body.		
Wags head.		
Rotates or twirls body.		
Waves or flicks finger(s) near eyes.		
Paces.		
Walks with bouncing gait.		
Has spurts of running.		
Comments:		

Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Proprioception Assessment

Muscle Tone *(problem not due to neuromuscular diagnosis)*	**Yes**	**No**
Lacks well defined body contours.		
Tires easily.		
Passive unless encouraged or assisted in movement.		
Demonstrates a weak grip.		
Speech is slurred or mumbled.		
Displays poor cocontraction.		
Exhibits hyperextension of elbows or knees.		

Comments:

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:	
Motor Skills/Planning & Body Image	**Yes**	**No**
Is clumsy or awkward in movement.		
Does not position self squarely on furniture or equipment.		
Is awkward when getting on or off equipment.		
Does not shape hand to hold objects or another's hand.		
Holds object placed in hand instead of manipulating it.		
Looks at hand to reach accurately or perform familiar tasks.		
Touches, or holds objects lightly.		
Is physically rough with people and objects.		
Pinches when attempting to grip.		
Uses "high stepping" when ascending or descending stairs.		

Comments:

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Self-Stimulatory Behaviors	Yes	No
Flaps hands, claps, jumps, hops, and stamps, to an unusual degree.		
Toe-walks.		
Pulls against object clenched in teeth.		
Presses or bangs heels or wrists.		
Climbs in inappropriate places.		
Pushes or leans heavily against people or furniture.		
Grinds/clenches teeth.		
Bites objects/others.		
Comments:		

Self-Injurious Behaviors	Yes	No
Butts head or body against stationary objects.		
Bangs head.		
Slaps/hits self.		
Bites hand/wrist/arm.		
Comments:		

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Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:	
General Reactions	**Yes**	**No**
Difficulty with transitions between activities, places, people.		
Unpredictable emotional outbursts.		
Slow to recover or hard to calm when upset.		
Delayed response to social communication or sensations (pain, touch, sound, smell, light).		
Does not respond to sensations (pain, touch , sound, smell, light).		
Hypersensitive to sensations (touch, sound, smell, light).		
Makes repetitious 'vocal' sounds.		
Difficulty orienting to others, activity.		
Distractable, short attention to task.		
Comments:		
Are the indicators selected long standing, or recent?		

Occupational Therapy Sensory Questionnaire *(continued)*

Child's Name:	Date of Birth:

Additional Information

Primary and Specialty Care Providers (pediatrician, other medical personnel):

Present Weight (lbs.):	Height (in.):

Feeding/Nutrition (list solid food/liquid food intake per day in ounces):

Allergies:

Sleeping pattern and habit:

Present family concerns and priorities:

Family support system and resources:

Other (i.e.,Additional medications, supplements, taken if any, or special diet):

adapted from *Sensory Inventory by Bonnie Hanschu, OTR

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