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Sensory Processing Profile Questionnaire

Date: _____
Name: _____
DOB: _____
Address: _____
_____
Name of Person Completing This Form:
_____
Relationship: _____
_____
Email address: _____

Home Phone: _____
Cell: _____
Is it ok to leave phone and/or email messages?
Yes_____ No_____

Please check the appropriate box(es) for the following questions

Tactile (Touch)

	Yes	No	Used To	N/A
Dislikes the feeling of certain clothing				
Tends to wear layers of clothing				
Prefers to wear sleeveless shirts and/or shorts				
Over or under dresses for the weather/temperature				
Feels easily irritated when touched by others				
Has a strong need to touch objects or things				
Tends to touch others when speaking to them				
Is comfortable being hugged by others				
Is better when able to initiate hugging others				
Overheats easily				
Seems to lack the normal awareness of being touched				
Often seems unaware of cuts, bruises, pain, etc.				
Examines objects or clothes with hands				
Avoids using hands or may only use fingertips				
Seems overly sensitive to food or water temperature				
Prefers tub baths over showers				

Taste and Smell

	Yes	No	Used To	N/A
Eats a variety of foods				
Eats crunchy foods				
Eats chewy foods				
Eats soft foods				
Likes spicy foods				
Likes sweets				
Likes sour foods				
Chews on non-food items				
Hypersensitive to smell				
Smell objects, clothes or food more than usual				
Craves certain foods/drinks				
If yes, please list:				
_____				

Has food/drink allergies/sensitivities

If yes, please list:

_____

_____

Visual

Has seen an Optometrist? _____ Yes _____ No

If yes, Doctor's name/Address: _____

	Yes	No	Used To	N/A
Avoids eye contact				
Gets distracted by visual input				
Squints often				
Looks to side or down to see things up close				
Makes reversals when writing, copying or reading				
Has good depth perception				
When reading:				
Skips words/lines				
Loses place				
Reads slowly				
Uses finger as a marker				
Has good comprehension				
Has sensitivity to light				

Auditory

	Yes	No	Used To	N/A
Has a hearing loss				
Has a history of ear infections and/or has ear tubes				
Has hypersensitivity to sounds				
Has a fear of unexpected noises				
Has difficulty listening				
Has trouble locating sound				
Has sensitivity to certain voices or voice pitches				
Has sensitivities to certain sounds, i.e., vacuum/hair dryer, etc.				
Has difficulty blocking background noise/conversations				
Hears sounds others don't hear or before others notice				
Misponounces words				
Has a tendency to stutter				

Vestibular/Proprioception

	Yes	No	Used To	N/A
Has difficulty sitting still				
Gets motion sickness, and/or gets carsick				
Has a fear of heights and/or avoids climbing				
Hesitates or has difficulty going down stairs				
Trips easily and/or frequently falls				
Dislikes elevators or escalators				
Resists having head tilted backwards				
Enjoys swinging/sliding, etc.				
Rocks while sitting				
Has a tendency to confuse right and left when following verbal directions				
Sleeps with heavy blankets/comforters				
Seems fearful of catching balls				

Personal Characteristics/Concerns

	Yes	No	Used To	N/A
Active, outgoing				
Intense, anxious				
Explosive, aggressive				
High activity level				
Easy going, predictable				
Low activity level				
Rigid, set in ways				
Adaptable, flexible				
Distractible				
Moody				
Frustrated frequently				
A perfectionist				
Have erratic sleep patterns				
Have regular sleep patterns				
Have difficulty getting to sleep				
Wakes frequently				
Has nightmares				
Has a short attention span				
Has difficult making choices				
Has difficulty with changes/transitions				
Has low self-esteem