

Sensory Processing/Developmental History Checklist Ages 3-6

Child's Name: _____ DOB: _____ Age: _____
Parents/Guardians Name(s): _____
Address: _____ City: _____ ST: _____ Zip: _____
Phone (H) _____ (Cell) _____ (Work) _____
Medical History: _____
Hospitalizations: _____
Surgery: _____
Ear Infections: _____ Frequency: _____
PE Tubes in Ears: _____ Date(s): _____
Allergies: _____
Medications: _____
Diagnosis: _____

Birth History: (circle all that apply)

Premature _____ Number of weeks? _____
Vaginal _____ C-section _____ Scheduled/ Emergency _____
Forceps for delivery _____ Vacuum for delivery _____ Breech (feet first) _____
Required NICU hospitalization _____ How long? _____

Infancy and Early Childhood

Sleeping problems:

Feeding problems: Colic _____ Reflux _____ Other problems: _____

Preferred positions as infant (describe): _____

Movement (circle): Assists in calming child _____ Made child nauseated _____

Crawling phase: absent _____ brief _____ commando _____ creep on all 4's _____

Experienced delays/hesitancy with stairs, stepping over objects, off curbs _____

Delays in developmental milestones: _____

Describe child's behavior (terrible two's) (current): _____

Parent Concerns:

Circle areas of difficulty. Make comments as apply to your child. If he/she has many problems in one area, or several items in 3 or more categories, call PTS to refer for an occupational therapy evaluation.

Vestibular system, Movement, Balance

Tended to arch back when held or moved as an infant

Fear of climbing, falling when no danger exists
Has excessive dizziness /nausea from swinging, riding in car,
Dislikes being moved by someone else, having feet off the ground
Seeks intense movement compared to peers
Can't sit still
Shakes head vigorously, assumes upside down positions more frequently than peers
Trips easily, clumsy

Proprioceptive Functioning (Body Awareness)

Plays roughly with people or objects
Uses too little or too much force
Bumps into things/poor body awareness in relation to objects in environment
Seeks to crash or fall into things more than peers
Stamps or slaps feet when walking
Walks on toes frequently
Wants prolonged hugs or gives prolonged hugs
Poor posture

Tactile (Touch) Processing

Withdraws from cuddling, touch by parents
Complains about clothing textures (tags, socks, wants clothes very loose or very tight)
Dislikes a variety of food textures (picky eater)
Withdraws from light touch such as showering, playing in sprinkler
Avoids play with messy materials (finger paints, glue)
Tantrums with hair cutting nail trimming, hair cuts

Visual Motor Integration/Fine Motor Skills

Difficulty tracking objects in horizontal, vertical or circular planes
Poor eye contact
Problems coordinating eyes with reach and grasp
Difficulty completing simple puzzles, blocks, turning dials on age appropriate toys
Problems brushing teeth with horizontal and vertical movements
Problems using age appropriate toys or tools such as play hammer, scissors, spoon, fork
Sensitive to bright lights compared to peers

Self-Care Skills

Has difficulty using utensils, drinking from an open cup or using a straw
Has difficulty undressing/dressing self
Has not developed predictable sleep schedules
Has difficulty with buttons, zippers, snaps, belts on clothing

Play /Social Skills/Emotional Attachment/Behavior

Does not demonstrate creative/imitative play

Wanders around playroom or playground unable to initiate purposeful play

Does not have favorite games, songs or toys

Often breaks toys or other things destructively

Prefers to play with objects rather than people

Self abusive (bangs head, bites self, scratches self until bleeds)