SENSATIONAL PARENTING

OFFERING SENSATIONAL SUPPORT

SENSORY CHECKLIST

Instructions: Please answer the following questions based on your child's behaviors and preferences.

Visual Sensation

Does your child react strongly to bright lights?

☐ yes ☐ no ☐ not sure

Does your child have specific color preferences or aversions?

☐ yes ☐ no ☐ not sure

Does your child seem bothered by visual patterns or stimuli?

☐ yes ☐ no ☐ not sure

Auditory Sensation (sound)

Does your child cover their ears in response to loud noises?

☐ yes ☐ no ☐ not sure

Is your child sensitive to specific sounds or noises?

☐ yes ☐ no ☐ not sure

Does your child have difficulty tolerating background noise?

☐ yes ☐ no ☐ not sure

Tactile Sensation (touch)

Does your child avoid certain textures of clothing?

☐ yes ☐ no ☐ not sure

Is your child sensitive to touch or hesitant about being touched?

☐ yes ☐ no ☐ not sure

Does your child have specific preferences for tactile experiences?

☐ yes ☐ no ☐ not sure

Olfactory Sensation (smell)

Does your child react strongly to certain smells?

☐ yes ☐ no ☐ not sure

Does your child have a strong aversion to certain odors?

☐ yes ☐ no ☐ not sure

Does your child seek out or avoid certain scents?

☐ yes ☐ no ☐ not sure

Gustatory Sensation (taste)

Does your child have strong preferences or aversions to certain tastes?

☐ yes ☐ no ☐ not sure

Is your child particular about food temperatures?

☐ yes ☐ no ☐ not sure

Does your child have specific texture preferences in food?

☐ yes ☐ no ☐ not sure

Proprioceptive Sensation (pressure and position)

Does your child seek out or avoid certain types of movement?

☐ yes ☐ no ☐ not sure

Does your child appear to have difficulty with body awareness?

☐ yes ☐ no ☐ not sure

Is your child comforted by heavy work or pressure?

☐ yes ☐ no ☐ not sure

Vestibular Sensation (movement)

Does your child experience motion sickness easily?

☐ yes ☐ no ☐ not sure

Does your child have balance preferences or challenges?

☐ yes ☐ no ☐ not sure

Does your child enjoy specific types of movement (e.g., swinging, spinning)?

☐ yes ☐ no ☐ not sure

Interoceptive Sensation (inside)

Is your child aware of internal sensations like hunger, thirst, or fatigue?

☐ yes ☐ no ☐ not sure

Is your child comfortable with bodily functions?

☐ yes ☐ no ☐ not sure

Does your child have temperature sensitivity?

☐ yes ☐ no ☐ not sure

This survey is a starting point, and it is not a formal evaluation of sensory processing. After filling out the checklist, consider consulting with healthcare professionals or specialists for a more comprehensive assessment if needed.

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