

## **Sensory Processing Screening Form**

Student/Person's name: .....

DOB:.....

Person(s) completing form: .....

Date: .....

**1.) Has the person been seen by an occupational therapist in the last two years? Yes/ No**

If yes, please provide more information about the reasons for the occupational therapy referral:

.....

.....

.....

.....

**2.) Has the person had a sensory assessment completed in the past? Yes/No**

If yes, When? ..... Do you still have a copy that you would be willing to forward to QAC? Yes/No

*If the sensory assessment was carried out in the last three years and you have a copy to forward to QAC then you do not need to complete any more of this form.*

**3.) In your opinion / the opinion of others, does the person have sensory issues? (Problems with the sensory environment/ processing sensory information i.e. noise, smells, touch, etc) Yes/No**

**4.) In your opinion/ the opinion of others, do sensory problems impact on the person's daily life? Yes/No**

**5.) For each behaviour described in the table, please tick the box that represents the frequency with which this behaviour has occurred over the last 12 months.**

	Behaviour	Rarely/ Never	Sometimes	Often	Additional comments to explain the behaviours in more detail
<b>Auditory</b>	Becomes distressed in noisy places /crowds i.e. canteen, shopping centres, etc				<p>Are there any other issues with noise that you can think of? The college environment can be very noisy at times – would this person cope in noisy places like the canteen?</p> <p>Does the person have any strategies or ways of coping with noise if they don't like it? i.e. headphones, ear defenders, do they leave the room, etc.?</p>
	Hums, whistles, sings or makes other repetitive sounds throughout the day				
	Would be described as 'noisy'				
	Is distracted or has difficulty functioning if there is a lot of noise in the environment				
	Has been observed covering their ears/ sticking their fingers in their ears				
	Seems to be a light sleeper				
<b>Visual</b>	Rapidly moves fingers or objects in front of their eyes				<p>In relation to visual processing, is there any more important information i.e. anything unusual that they do with their eyes? Do they sit too close to the TV or screen?</p>
	Avoids eye contact with familiar/ unfamiliar people (delete if appropriate)				
	Squints, rubs eyes or has watery eyes				
	Watches everyone when they move around the room				
	Has been observed covering their eyes				
	Has difficulty telling the difference between different colours, shapes, sizes				
<b>Smell and Taste</b>	Poor depth perception or hand/eye coordination				<p>Are there any other issues with the person's sense of smell or taste that you can think of? Do they avoid certain places/food because of the smell or taste?</p>
	Eats things that shouldn't be eaten i.e grass, pritt stick, etc...				
	Licks, chews or mouths objects/clothing				
	Adds a lot of condiments/ sauce/ seasoning to foods				
	Seems to be a picky eater				
	Gags or vomits easily				
<b>Smell and Taste</b>	Sniffs objects/people				
	Appears to dislike strong smells e.g. cleaning fluid, perfumes, cooking smells				

	Is bothered by smells not usually noticed by others				
	Tells other people (or talks about) how bad / funny they smell				
<b>Tactile / Touch</b>	Resists being touched (besides from family)				Do you feel that there are any issues with touch that would affect the person at college?
	Shows displeasure when hair or face is washed/ hair is brushed/ hair is cut/ teeth are brushed/ nails are cut (delete as appropriate)				
	Seeks pressure				Does the person have any specific issues with temperature regulation? Do they feel cold when the temperature drops/ warm when it's warm, etc.?
	Dislikes new clothes and shoes/ pulls at clothing and underwear/ dislikes seams and labels in clothes/ irritated by tight cuffs, collars or waistbands (delete as appropriate)				
	Doesn't notice when hands or feet get dirty, food has spilled on their face or if their nose is running				
	Seems to seek touch and repeatedly touches surfaces /objects that are soothing i.e. blankets, toys				Does the person recognise when they are hungry and full?
	Seems to overreact or under react to pain/ temperature/ minor cuts, bruises, insect bites				
	Avoids touching objects /uncomfortable touching objects/ people (i.e. hand shakes)				
<b>Balance and Coordination</b>	Enjoys rocking (when standing or sitting), jumping or swinging activities				Are there any other issues with spatial awareness, balance or coordination that is useful to know?
	Always seems to be "on the go"				
	Seeks all kinds of movements and this interferes with their daily routines				What support does the person need to feed themselves?
	Avoids riding equipment that moves through space i.e. swings, escalators, lifts, etc				
	Shows a lack of confidence when walking on uneven surfaces / seems fearful of ramps and inclines and is apprehensive when climbing hills or stairs				
	May be fearful of / have difficulty with riding a bike, jumping, hopping, balancing on one foot				
	Loses balance easily and may appear clumsy				

Person has problems with fine motor skills e.g. buttons, holding a pencil				What is the person's concentration and attention like? Can they concentrate on something they are enjoying for enough time to complete the activity?
Bumps into people, furniture or objects in their environment				
Accidentally spills when opening containers, pouring or drinking				
Person seems to do everything with too much force or too little force i.e. slamming doors, pressing too softly with a pen, etc				
Can the person use cutlery to feed themselves? Please provide further details in the box opposite if no.				
Generally has poor coordination and balance				

Does the person have a hearing impairment?	Yes / No
Does the person have a history of frequent ear infections?	Yes / No
Does the person have a visual impairment?	Yes / No
Is the person dyslexic?	Yes / No
Is the person a wheelchair user?	Yes / No
Does the person have mobility issues/ a movement disorder?	Yes / No
Does the person have poor muscle tone?	Yes / No
Has the person ever had any surgery related to their sinuses/ nose/ throat / swallowing?	Yes / No

**This space is for you to provide any further details in relation to the person's sensory needs i.e. any past strategies that have been successful or anything that you would like to try or want to know more about:**

.....

.....

.....

.....

.....

.....

**The information that you have provided in this form will be used to determine whether or not the person requires a more in depth sensory assessment to enable them to access the college environments successfully. For further support and information please email Pagan Darnell (occupational therapist) at [pdarnell@gac.ac.uk](mailto:pdarnell@gac.ac.uk)**