

Individual Sensory Learning Profile
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Updated by DeEtte Snyder, MS Ed. 2006

Child's Name:

D.O.B.: Current Age:

Date: Completed By:

School District:e

Please complete with the child's primary caregiver and the child's early interventionist, special education teacher, and/or therapist

Background Information

Medical Diagnosis:

Birth History:

Current Medications and Why They Are Taken:

What educational services has the child been receiving?

Sensory Profile Questions

Vision

Does the child have a diagnosis as being blind or visually impaired? Yes: No:

If so, what is the medical diagnosis?

Who is the ophthalmologist?

When was the most recent visit and is an eye report on file?

Does the child wear glasses or use other optical devices? If so please give the prescription and/or details about the devices.

Right Eye: *Left Eye:* *Both Eyes:*

Is the child participating in a patching program? Yes: No:

Which eye? Right Left Alternating left and right? For how long?.

Does the child visually respond to a human face? Yes: No:

Does the child respond to other visual stimuli? Yes: No:

If so, what are the characteristics of the visual stimuli?

Illumination *Shiny/Light Reflective* *High Contrast*

Pastel colored *Brightly Colored* *Familiar*

Please describe other characteristics or details about visual stimuli:

Is there an immediate or delayed response to visual stimulus? Please describe:

What type of environment seems to best support visual responsiveness?

Presentation to midline *left* *right* *top* *bottom of visual field*

visual attention distance (describe in inches or feet)

illumination preference

familiar setting/items *quiet* *low visual clutter*

Other environmental preferences including positioning needs for visual attending:

Accompaniments of other sensory stimuli (Can they look and touch or listen at the same time?) describe:

Items that child shows a visual response/preference to (What are their favorite things to look at?):

Hearing

Does the child have a diagnosis of being deaf or hard of hearing, or have a central auditory processing disorder? If so, please circle the one(s) that are appropriate. Yes: No:

Does the child wear hearing aids or use other sound amplification devices? Yes: No:

If yes, please list the listening devices used such as hearing aids and/or FM systems:

Is there a history of ear infections? Yes: No:

Does the child attend to auditory stimuli? Yes: No:

If so, what are the characteristics of the auditory stimuli?

Human Voice: Yes: No:

Environmental Sounds: Yes: No:

Sound volume: Low Moderate High

Other characteristics or details about auditory stimuli:

Is there an immediate or delayed response to auditory information? Please describe.

What type of environment seems to best support auditory responsiveness?

Sound presentation distance (describe in inches or feet)

quiet *low noise clutter* *echolocation boundaries*

Accompaniment of other sensory stimuli:

Other environmental preferences for auditory responsiveness:

Items that child shows an auditory response/preference to (What do they like to listen to?)

Touch

Does the child respond positively or adversely to being touched? Positively: Adversely:

Please explain preferences or aversions for being touched (e.g., soft, firm, predictable)

Does the child respond positively or adversely to touching people/objects?
Positively: Adversely:

Please explain preferences or aversions for touching people/objects with hands, feet, mouth, or their body. (i.e. can the child touch grass, any feeding difficulties, do they use their hands or feet more, do they explore textured books, etc...):

Please describe any visual-motor behaviors (For instance, can the child look and reach at the same time?):

Kinesthetic/Vestibular

Does the child have a diagnosis of cerebral palsy or other disorder affecting movement?
Yes: No:

Does the child benefit from any orthopedic or special positioning/ambulation/mobility device?
Yes: No:

Please list these device(s):

Does the child respond positively or adversely to movement: Positively: Adversely:

Please explain preferences or aversions to movement (e.g., slow, rhythmic, predictable, etc.):

How does the child move around in his environment?

Positions which seem to best support overall sensory responsiveness:

Prone *Supine* *Sidelying* *Sitting independently* *sitting with support*

Other:

Olfactory/Taste

Does the child positively or adversely respond to specific smells and/or tastes? Please describe:

Positive responses:

Aversive responses:

Summary of Sensory Preference and Recommendations for Motivating Objects

Visual:

Auditory:

Touch/Movement:

Smell/Taste:

Other Recommendations: