Individual Sensory Learning Profile

Developed by Tanni L. Anthony, Ph.D., 1997, 2003, 2005

Child's Name: _____

DOB: _____ **Current Age**: _____

Date: _____ **Completed By**: _____

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

Background Information

Medical Diagnoses:

Current Medications and Why They Are Taken:

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?

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:* _____

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

An adapted version of this protocol is published in: Anthony, T. L., Shier Lowry, S., Brown, C. J., & Hatton, D. D. (2004). *Developmentally Appropriate Orientation and Mobility*, Chapel Hill: University of North Carolina at Chapel Hill.

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

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

_____ *Illuminating* _____ *Shiny/Light Reflective* _____ *High Contrast*

_____ *Pastel Colored* _____ *Brightly Colored* _____ *Familiar*

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 (circle all that apply)

visual attention distance (describe in inches or feet) _____

illumination preference: _____

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

accompaniment of other sensory stimuli: _____

Other environmental preferences including positioning needs for visual attending:

Items that child shows a visual response / preference to:

Hearing:

Does the child have a diagnosis of being deaf, hard of hearing, or having a central 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?

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Yes ☐ No ☐

If yes, please list the listening devices used:

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:

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Touch / 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 being touched?
Positively: ☐ Adversely: ☐

Please explain preferences or aversions for being touch (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:

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

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

Positions which seem to best support overall sensory responsiveness:

prone _____ *supine* _____ *sidelying* _____ *sitting* _____

sitting with support _____ *other:*

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Olfactory / Taste

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

Positive responses:

Aversion responses:

Summary of Sensory Preference / Recommendations for Motivating Objects

Visual:

Auditory:

Touch/Movement:

Smell/Taste:

Other Recommendations:

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