SENSORY
LEARNING
INSTITUTE

ADULT SENSORY LEARNING PROGRAM SURVEY (Pre-Sessions) 1

This information will be treated confidentially.

Name: ______________________________ **Date:** ______________

Contact Information

Phone:

Cell:

Address:

Present Health History

1. Current Medications:

2. Current Supplements/Vitamin Therapies:

3. Recent Illnesses:

4. Recent Traumas:

5. Current Treatment/Therapy currently receiving:

6. Recent progress achieved in current Treatment/Therapies:

General Assessment

Please answer the following questions according your most recent experience. Please make any notes you feel are relevant.

7. Do you enjoy strong sensations, e.g., being hugged tightly?

8. Do you enjoy fast-moving or spinning activities, with little or no apparent dizziness?

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9. Are you unusually sensitive to smell?

10. Do you have concerns about your hearing? If so, please describe.

11. Are you sometimes confused by the direction of sounds?

12. Are you startled or irritated by sounds that don't bother others?

13. Do you have difficulty paying attention amid surrounding noise?

14. Do you become confused or irritated when presented with a lot of visual stimuli?

15. Are you sensitive to, or startled by sudden changes in light? (Squinting, Covering eyes, being startled by lights turned on?)

16. Do you avoid certain textures of food, e.g., preferring only soft, creamy?

17. Do you have difficulty organizing your body for new activities? (navigating a new trail, learning a new sport)

18. Do you have a hand preference for eating or drawing? Which hand?

19. Do you avoid active physical play such as running, using playground equipment, group games?

20. Do you avoid games and tasks that involve manipulating small objects?

21. Do you have a short attention span even for things that you enjoy?

22. Do you seem to ignore or be unaware of physical pain?

23. Do you dislike being touched, especially unexpectedly?

24. Do you crave firm touch?

25. Are you sensitive to movement in cars or on rides, e.g., getting dizzy or nauseous easily?

26. Do you have poor balance?

27. Do you feel fearful in “off the ground” activities, e.g., on the stairs, on swings, on slide?

28. Do you use extraneous movements during physical activities, e.g., sticking out tongue, clenching fists, moving jaw?

29. Are you restless or fidgety?

30. Do you tire easily?

31. Are you restless at bedtime?

32. Do you wake once or more during the average night? Please describe.

33. Do you express affection?

34. Please describe any sensitivities to light, sound or movement:

35. Please describe any behaviors that seem unique to you in specific situations.

Additional Comments

Please write any additional comments in the space below or on the back of this sheet.