

Sensory Assessment Checklist

Patient's name: _____ Date of birth: _____

Assessment date: _____ Age at assessment: _____

Instructions: Review the behaviors listed under each sensory system and check all that apply.

System	Behaviors	Place a checkmark if the behavior applies	Comments
Auditory system <i>Hearing and sound sensitivity</i>	Reacts strongly to loud noises (e.g., covers ears, cries)		
	Easily distracted by background noise		
	Enjoys making loud sounds (e.g., banging objects, yelling)		
	Struggles to follow verbal instructions in noisy environments		
	Does not respond to name being called		
Visual system <i>Sight and light sensitivity</i>	Sensitive to bright lights or prefers dim lighting		
	Struggles with eye contact or avoids visual focus		
	Easily distracted by visual stimuli (e.g., moving objects, patterns)		
	Difficulty tracking objects or following moving stimuli		
	Enjoys watching spinning or flashing lights		
Tactile system <i>Touch and texture sensitivity</i>	Avoids certain clothing textures or tags		
	Seeks out or avoids messy play (e.g., sand, finger paint)		

System	Behaviors	Place a checkmark if the behavior applies	Comments
Tactile system <i>Touch and texture sensitivity</i>	Reacts negatively to light touch but enjoys deep pressure		
	Frequently touches objects and people		
	Dislikes having hands or face messy		
Vestibular system <i>Balance and movement awareness</i>	Enjoys spinning, jumping, or swinging excessively		
	Avoids activities that require balance (e.g., climbing stairs, riding a bike)		
	Becomes dizzy easily or never seems to get dizzy		
	Prefers being in constant motion		
	Fearful of feet leaving the ground		
Proprioceptive system <i>Body awareness and coordination</i>	Frequently bumps into objects or people		
	Enjoys tight hugs or weighted blankets		
	Difficulty judging personal space		
	Struggles with fine motor tasks (e.g., buttoning clothes, handwriting)		
	Seeks deep pressure (e.g., pressing against walls, squeezing objects)		

System	Behaviors	Place a checkmark if the behavior applies	Comments
Gustatory and olfactory system <i>Taste and smell sensitivity</i>	Avoids or craves strong tastes (e.g., spicy, sour foods)		
	Chews on non-food items (e.g., pencils, clothing)		
	Overly sensitive to certain smells or unaware of strong odors		
	Limited diet due to food texture preferences		
	Frequently sniffs or licks objects		
Interoceptive system <i>Internal body awareness</i>	Difficulty recognizing hunger or thirst cues		
	Unaware of needing to use the bathroom		
	Struggles with body temperature regulation		
	Does not recognize pain or reacts strongly to minor injuries		
	Complains of discomfort without clear cause		
Additional notes			

Disclaimer: This Sensory Assessment Checklist is intended for informational purposes only and is not a diagnostic tool. If multiple behaviors are checked or if there are concerns about sensory processing, further assessment or evaluation is needed.