

Individual Sensory Learning Profile Interview

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

Child's Name: _____

DOB: _____ Current Age: _____

Date: _____ Completed By: _____

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

Background Information

Medical Diagnoses:

Current Medications and their purpose:

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? Yes: _____ No: _____

If so, please give the prescription and/or details about the devices.

Glasses:

Right Eye _____ Left Eye _____ Both Eyes _____

Optical Device(s) (type and power):

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?

_____ *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)

focal 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 auditory processing disorder?

Yes _____ No _____

Does the child wear hearing aids or use other sound amplification devices?

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

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 _____

If yes, please list these device(s):

Does the child respond positively or negatively to being touched?
Positively _____ Negatively _____

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

Does the child respond positively or negatively to touching people/objects?
Positively _____ Negatively _____

Please explain preferences or aversions for touching people/objects:

Does the child respond positively or negatively to movement?
Positively _____ Negatively _____

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

Positions which seem to best support overall sensory responsiveness:

prone (on stomach) _____ *supine (on back)* _____ *sidelying* _____

sitting _____ *sitting with support* _____ *other* _____

Olfactory/Taste

Does the child positively respond to specific smells and/or tastes?
Yes _____ No _____

If yes, please describe:

Does the child negatively respond to specific smells and/or tastes?

Yes _____ No _____

If yes, please describe:

Summary of Sensory Preference / Recommendations for Motivating Objects

Visual

Hearing

Touch/Movement

Smell/Taste

Other Recommendations