**Sensory Needs Questionnaire**

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| **About Your Child** | | | | | | | | |
| **Name:** | | |  | | | | | |
| **Date of Birth:** | | |  | | | | | |
| **Diagnoses: *(Please tick)*:** | | | | | | | | |
| **Autism** |  | **ADHD** | |  | **Learning Disability** | |  | |
| **Any other diagnoses (Please list):** | | | | | | | | |
| **Your Child’s Services** | | | | | | | | |
| **Please list the services your child uses and what the services provide** | | | | | | | | |
| **Name of Service** | | | **What the service provides** | | | | | |
| **Example: Thinking Big Friends and Family Hub.** | | | **Example: Support network for parents of children with disabilities with visiting speakers talking about relevant issues.** | | | | | |
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| **Your Child’s Needs** | | | | | | | | |
| **Does your child need more support with? *(Please tick)*** | | | | | | **Yes** | | **No** |
| **Eating a wider range of foods** | | | | | |  | |  |
| **Tolerating hands and face washing** | | | | | |  | |  |
| **Tolerating bathing / showering** | | | | | |  | |  |
| **Tolerating hair washing, brushing and cutting** | | | | | |  | |  |
| **Tolerating teeth brushing** | | | | | |  | |  |
| **Tolerating wearing clothes and shoes** | | | | | |  | |  |
| **Toilet training / toileting** | | | | | |  | |  |
| **Sleeping** | | | | | |  | |  |
| **Coping with nursery / school** | | | | | |  | |  |
| **Finding things to do to occupy them e.g. toys and activities** | | | | | |  | |  |
| **Coping with going to the shops and other community activities e.g. swimming** | | | | | |  | |  |
| **Your Child’s Reactions to Sensations** | | | | | | | | |
| **Does your child need more support for coping with? *(Please tick)*** | | | | | | **Yes** | | **No** |
| **Sounds bothering them or them finding ways of making lots of noise** | | | | | |  | |  |
| **Things they see bothering them or them staring at things** | | | | | |  | |  |
| **Things touching them (e.g. clothes, people) or them touching things a lot** | | | | | |  | |  |
| **Smells and tastes or them smelling things a lot and mouthing non-foods** | | | | | |  | |  |
| **Movement e.g. them disliking riding in a car or them moving about a lot** | | | | | |  | |  |
| **Your Child’s Activity Levels** | | | | | | | | |
| **Does your child need more support for keeping their activity level at the right level for doing things properly? *(Please tick)*** | | | | | | **Yes** | | **No** |
|  | |  |
| **If yes, my child’s activity level is usually: *(Please tick)*** | | | | | | | | |
| **Too low**  **(underactive)** |  | **Too high (hyperactive)** | |  | **Changing rapidly** | |  | |
| **Your Child’s Behaviours** | | | | | | | | |
| **Do you need support for understanding your child’s behaviours? *(Please tick)*** | | | | | | **Yes** | | **No** |
|  | |  |
| **If yes please give details of the behaviours:** | | | | | | | | |
| **Your Childs Safety Issues** | | | | | | | | |
| **Do you need more support to help keep your child safe at home or outside? *(Please tick)*** | | | | | | **Yes** | | **No** |
|  | |  |
| **If yes please give details of the safety issues:** | | | | | | | | |
| **Is there any further information you would like to add?** | | | | | | | | |
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| **Please note:** This information will be used to help us develop our services and will then be retained on our records. We do not pass on your information to third parties. Please return this questionnaire to the email or postal address below. | | | | | | | | |