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 ☐

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?

If yes, please list the listening devices used:

Yes ☐ No ☐

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 □ 

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:

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: