



Name of Participant: _____ Age: _____

SWSRA Sensory Participant Information

1. What is the primary objective of your child's visit to the sensory room?

Focus Exploration Relaxation Regulation of Mood

Sensory Engagement (if checked please elaborate on which senses): _____

2. How does your child communicate?

Verbally Non-Verbal Sign Language

Communication Device Combination (please explain): _____

3. What type of sensory activities would your child *benefit* from the most?

Sound Touch Sight Smell

Movement Other: _____

4. Is your child *hypersensitive* to any of the following things (is there anything we should be aware of that your child does *NOT* enjoy)?

Sound Touch Sight Smell

Movement Other: _____

5. Does your child have seizures or has your child ever had a seizure?

Yes No

6. Is there anything else that the Sensory Depot staff should be aware of:

