Name:

DOB:

7 SENSES THERAPY SCREENER

(Please circle or underline Y for Yes and N for No)

FINE MOTOR

Pre-Writing Skills

Does your child grasp (hold) the writing tool differently from other children? Y N

Is your child's handwriting (spacing, letter formation and or placement) difficult to read and follow? Y N

Does your child express dislike, hand fatigue or discomfort during writing tasks? Y N

Does your child color outside the lines? Y N

Does your child press light/hard on the paper when coloring, writing, or drawing? Y N

Object Manipulation Skills

Does your child have difficulty picking up small items such as jelly beans or cereal from a flat surface? Y N

Using the same hand, does your child have trouble moving objects from their palm into their fingertips? (Ex. Placing 2 or more coins into a vending machine) Y N

Does your child find it difficult to perform self help tasks such as buttons, zippers, snaps, and or shoe tying? Y N

Does your child drop items frequently? Y N

Does your child have difficulty using scissors to cut? Y N

Total number of No's:_____

GROSS MOTOR

Range of Motion and Strength

Does your child avoid physical play, such as jumping rope, or playing ball? Y N

Does your child need more help to throw or kick a ball? Y N

Does your child appear to get tired quickly when engaged in a physical task? Y N

Does you child display poor posture when sitting at the table or when playing? Y N

Does your child find it difficult to maintain certain positions such as standing on one foot or balancing? Y N

Coordination

Does your child have difficulty riding a bike, tricycle, or scooter..etc? Y N

Does your child appear clumsy when walking, jumping, or running? Y N

Does your child need help completing the sequence to a motor task, such as step by step directions to cross the monkey bars, slide down the slide, or climb up a playground ladder? Y N

Does your child have difficulty aiming at a target when throwing or trouble catching or hitting a tossed ball? Y N

Does your child have difficulty attaining a new skill, such as swimming? Y N

Total number of No's:_____

SELF-HELP SKILLS

Activities of Daily Living

Does your child have difficulty completing age appropriate tasks such as: getting dressed, washing hands, brushing teeth, toileting, or combing hair? Y N

Does your child have difficulty using utensils appropriately when eating? Y N

Does your child have trouble recognizing left from right or vice versa? Y N

Does your child have difficulty completing chores around the house or other jobs that require sequencing, such as making the bed, or pouring a bowl of cereal? Y N

Does your child need help staying on task and following directions? Y N

School Tasks

Does your child have trouble organizing papers for school or keeping a neat desk? Y N

Does your child have difficulty carrying the lunch tray to the table? Y N

Does your child need help following verbal instructions to complete activities or assignments? Y N

Does your child forget or lose track of items during the school day? Y N

Does your child need assistance to open containers and other lunch items? Y N

Total Number of No's:_____

SENSORY PROCESSING

Self-Regulation

Does your child enjoy running, jumping, crashing and have lots of extra energy? Y N

Does your child have a short attention span? Y N

Does your child have less energy and appear more passive than other peers? Y N

Does your child overly enjoy (always want) movement tasks such as swinging, jumping, and sliding? Y N

Is your child nervous of movement tasks such as swinging, climbing, and sliding? Y N

Senses

Is your child a picky eater? Y N

Does your child have sensitivities to certain textures/activities, such as clothing, play-doh, lotions, haircuts, nail trimming, interacting with peers or attempting messy play tasks? Y N

Does your child display repetitive behaviors, such as lining objects up, or opening and closing doors…etc? Y N

Does your child have an increased sensitivity to sounds or a decreased sensitivity to sounds? Y N

Does your child appear unhurt after falling or having an accident? (ex: not crying at all after skinning their knee) Y N

Total Number of No's:_____

~Please email or call us for your results~

7sensestherapy@gmail.com or 321-255-7779