Name: Evaluation Date: DOB:
Age (months and days): Observation Day/Time:
Name/Contact Info of Family:
Education Setting (Preschool name/times/days):

Sensory Processing*

Sensory System	Over-Responsiveness	Under-Responsiveness
Proprioceptive/ Vestibular		
Tactile		
Oral		
Auditory		
Visual		

*Ask Parent/Teacher what times/occupations are most impacted. Ask what strategies are already in place.

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