

# Sensory or Behavior Checklist

Name:		Date:	
Time of Observation:		Location of Observation:	
Observer/Title:			

Describe the overall behavioral outcome, episode or concern:

Describe what was occurring immediately before the undesired outcome:

Describe the child's reactions during the undesired outcome:

Describe any adult or peer reactions:

List the sensory characteristics of the activity or skill		List the sensory characteristics of the environment	
<input type="checkbox"/> tactile	<input type="checkbox"/> smell	<input type="checkbox"/> loud	<input type="checkbox"/>
<input type="checkbox"/> proprioceptive	<input type="checkbox"/> taste	<input type="checkbox"/> distracting	<input type="checkbox"/>
<input type="checkbox"/> vestibular	<input type="checkbox"/>	<input type="checkbox"/> small space	<input type="checkbox"/>
<input type="checkbox"/> visual	<input type="checkbox"/>	<input type="checkbox"/> large space	<input type="checkbox"/>
<input type="checkbox"/> auditory	<input type="checkbox"/>	<input type="checkbox"/> quiet	<input type="checkbox"/>

List any successful strategies that helped the child:

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Overall assessment:

**ACTION PLAN:**

- 1.
- 2.
- 3.