

Infants and Toddlers Checklist (Birth to Age Two)

The following checklist, provided by the Occupational Therapy Associates - Watertown, P.C., will provide you with a very detailed evaluation of sensory integration issues. If the child demonstrates behaviors associated with sensory integration dysfunction (DSI), it may be necessary to seek further information through evaluation by a qualified occupational or physical therapist.

Child's Name: _____ Date: _____

Check areas of difficulty; underline specific problems and star (*) prominent difficulties. If child has overall difficulty in one category or shows several items in three or more categories, this may indicate a need for an occupational therapist evaluation.

Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Dressing, Bathing, Touch				
1. Distressed when diapered or when diaper needs changing.				
2. Prefers certain clothing, complains that certain garments are too tight or itchy (for infants over 15 months).				
3. Distressed by having hair or face washed, or bathing.				
4. Distressed when clothes removed.				
5. Resists cuddling, pulls away or arches.				
6. Doesn't notice pain when falling, bumping, or when the doctor gives shots.				
7. Dislikes messy play.				
Movement				
1. In constant motion, rocking, running about, unable to sit still for an activity.				
2. Absent or brief crawling before walking (over 1 year).				
3. Distressed by being swung in air, swings, merry-go-rounds, car rides.				
4. Craves swinging and moving upside down.				
5. Clumsy, falling, poor balance, bumps into things (over 1 year).				
6. Fearful or hesitancy moving over changing surfaces (e.g., sidewalk to grass, carpet to wood floor).				

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Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Listening, Language, and Sound				
1. Distressed by common sounds (e.g., music, singing, vacuuming, flushing toilet, raised voices).				
2. Doesn't respond to verbal cues (hearing not a problem over 1 year).				
3. None or very little vocalizing or babbling.				
4. Distracted by sounds not normally noticed by average person (e.g., furnace, refrigerator).				
Looking and Sight				
1. Sensitive to bright lights, cries or closes eyes.				
2. Avoids eye contact, turns away from the human face.				
3. Becomes overly excited or falls asleep in crowded, bustling settings such as a crowded supermarket, restaurant (over 1 year).				
4. Cannot pay attention with more than one toy or food item in view.				
Play Abilities				
1. Does not show ability for imitative play (older than 10 months).				
2. Wanders around aimlessly without focused exploration or purposeful play (over 15 months).				
3. Easily breaks toys and other things destructively (over 15 months).				
4. Needs total control of the environment ("runs the show").				
5. Amuses self appropriately for brief periods of time.				
6. Engages in repetitive play for long periods of time.				

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Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Emotional Attachment/ Emotional Functioning				
1. Prefers to play more with objects and toys than with people.				
2. Does not interact reciprocally (back and forth exchanges with caregiver).				
3. Hurts self or others (e.g., head banging, biting, or pinching).				
4. Everyone has difficulty understanding the child's cues or emotions.				
5. Does not seek connection with familiar persons.				
Self-Regulation				
1. Excessively irritable, fussy, colicky				
2. Can't calm self effectively by sucking on pacifier, looking at toys, or listening to caregiver (10 months and older).				
3. Can't change from one activity to another or from sleeping to awake without distress.				
4. Must be prepared in advance several times before change is introduced.				
Attention				
1. Easily distractible, fleeting attention				
2. Over focuses on one activity (e.g., TV, trains, wheels).				
3. Too distracted to stay seated for meals.				

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Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Eating, Sleeping				
1. Requires extensive help to fall asleep or wake up. Specify: rocking, long walking, stroking hair or back, car ride.				
2. Extreme food preferences for extended time periods.				
3. Excessive drooling beyond teething stage.				
4. Difficulty with sucking, chewing, or swallowing.				

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How concerned are you about the above checked problems? Not concerned Slightly Moderately Very

Questions/Comments:

Child's Name: _____ Birth Date: _____ Age: _____

Date Completed: _____ Parents' Name(s): _____ Phone: _____

Name of Case Manager/Therapist/Teacher: _____

Name of Early Intervention/Preschool: _____



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Preschool Checklist (Age Three to Four)

The following checklist provided by the Occupational Therapy Associates - Watertown, P.C. will provide you with a very detailed evaluation of sensory integration issues. If the child demonstrates behaviors associated with sensory integration dysfunction (DSI), it may be necessary to seek further information through evaluation by a qualified occupational or physical therapist.

Child's Name: _____ Date: _____

Check areas of difficulty: underline specific problems and star (*) prominent difficulties. If child has overall difficulty in one category or shows several items in three or more categories, this may indicate a need for an occupational therapist evaluation.

Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Motor Skills				
1. Difficulty riding a riding toy, with feet pushing or propelling.				
2. Difficulty or hesitancy in climbing up and/or down stairs alternating feet.				
3. Dislikes playing with puzzles.				
4 Dislikes or avoids coloring or drawing.				
5. Dislikes playing with small manipulative toys (e.g., Duplos, [®] beads, or blocks).				
6. Difficulty with the use of a spoon or cup.				
7. Has very messy eating habits.				
8 Seems weaker or tires more easily than other children his age.				
9. Appears stiff, awkward, or clumsy in movement.				
10. Difficulty learning new motor tasks.				
11. Has difficulty getting on coat with zipper or putting on shoes (not tying).				
12. Uses too much force when playing with toys or interacting with children or pets.				
13. Walks on toes, now, or in the past.				

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Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Movement and Balance				
1. Child appears to be in constant motion, unable to sit still for an activity.				
2. Appears fearful of going downstairs.				
3. Gets nauseated or vomits from other movement experiences, e.g., swings, playground merry-go-rounds.				
4. Seeks quantities of twirling or spinning.				
5. Needs quantities of stimulation on amusement park rides and swings.				
6. Hesitates to climb or play on playground equipment.				
7. Has trouble or hesitancy in learning to catch a ball.				
8. Dislikes active running games; (e.g., tag).				
9. Rocks himself/herself or bangs head when stressed.				
10. Seems to fall frequently.				
11. Has poor safety awareness when moving through space.				
12. Fearful of going down sliding board or on a swing.				

Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Touch				
1. Seems unaware of being touched or bumped.				
2. Seems overly sensitive to being touched, pulls away from light touch.				
3. Has trouble remaining in busy or group situations (e.g., circle time, recess).				
4. Complains that clothing is uncomfortable and/or bothered by the tags in the back of shirts.				
5. Resists wearing short-sleeved shirts or short pants.				
6. Continues to examine objects by putting in the mouth (past age of 18 months).				
7. Dislikes being cuddled/hugged unless on child's terms.				
8. Seeks quantities of jumping and crashing.				
9. Avoids putting hands in messy substances (e.g., Play-Doh, [®] finger paint, glue).				
10. Is a picky eater, refuses many foods.				
11. Pinches, bites, or otherwise hurts self.				
12. Often unaware of bruises and cuts until someone calls it to his or her attention.				
13. Seems overly sensitive to slight bumps or scrapes.				
14. Tends to touch things constantly.				
15. Frequently pushes or hits other children.				

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Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Auditory/Language				
1. Has or has had repeated ear infections.				
2. Particularly distracted by sounds, seeming to hear sounds that go unnoticed by others.				
3. Doesn't respond consistently to verbal cues.				
4. Is overly sensitive to mildly loud noises (e.g., bells, toilet flush).				
5. Is hard to understand when she/he speaks.				
6. Has trouble following 1-2 step commands.				
7. History of delayed speech development.				
Bowel and Bladder				
1. Late in achieving bowel and bladder control.				
2. Occasionally has accidents during the day.				
3. If accidents occur, child does not seem to be aware ahead of time that elimination is about to occur.				
Emotional				
1. Does not accept changes in routine easily.				
2. Becomes easily frustrated.				
3. Apt to be impulsive, heedless, accident-prone.				
4. Has frequent outbursts or tantrums				
5. Tends to withdraw from groups; plays on the outskirts.				
6. Has trouble making needs known in appropriate manner.				
7. Avoids eye contact.				

Preschool Checklist (Age Three to Four)

How concerned are you about the above checked problems? Not concerned Slightly Moderately Very

Questions/Comments:

Child's Name: _____ Birth Date: _____ Age: _____

Date Completed: _____ Parents' Name(s): _____ Phone: _____

Name of Case Manager/Therapist/Teacher: _____

Name of Early Intervention/Preschool: _____



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School-Age Checklist (Age Five to Twelve)

The following checklist provided by the Occupational Therapy Associates - Watertown, P.C. will provide you with a very detailed evaluation of sensory integration issues. If the child demonstrates behaviors associated with sensory integration dysfunction (DSI), it may be necessary to seek further information through evaluation by a qualified occupational or physical therapist.

Child's Name: _____ Date: _____

Check areas of difficulty: underline specific problems and star (*) prominent difficulties. If child has overall difficulty in one category or shows several items in three or more categories, this may indicate a need for an occupational therapist evaluation.

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Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Gross Motor Skills				
1. Seems weaker or tires more easily than other children his/her age.				
2. Difficulty with hopping, jumping, skipping, or running compared to others his/her age.				
3. Appears stiff and awkward in movements.				
4. Clumsy or seems not to know how to move body; bumps into things.				
5. Tendency to confuse right and left body sides.				
6. Hesitates to climb or play on playground equipment.				
7. Reluctant to participate in sports or physical activity; prefers table activities.				
8. Seems to have difficulty learning new motor tasks.				
9. Difficulty pumping self on swing; poor skills in rhythmic clapping games.				
Fine Motor Skills				
1. Poor desk posture (slumps, leans on arm, head too close to work, other hand does not assist).				
2. Difficulty drawing, coloring, copying, cutting—avoidance of these activities.				
3. Poor pencil grasp; drops pencil frequently.				
4. Pencil lines are tight, wobbly, too faint or too dark; breaks pencil more often than usual.				
5. Tight pencil grasp: fatigues quickly in writing or other pencil and paper tasks.				
6. Hand dominance not well established (after age six).				
7. Difficulty in dressing; clothing off or on, buttons, zippers, tying bows on shoes.				

Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Touch				
1. Seems overly sensitive to being touched; pulls away from light touch.				
3. Has trouble keeping hands to self, will poke or push other children.				
4. Touches things constantly; "learns" through his/her fingers.				
5. Has trouble controlling his interactions in group games such as tag, dodge ball.				
6. Avoids putting hands in messy substances (clay, finger paint, paste).				
7. Seem to be unaware of being touched or bumped.				
8. Has trouble remaining in busy or group situations; e.g., cafeteria, circle time.				
Movement and Balance				
1. Fearful moving through space (teeter-totter, swing.)				
2. Avoids activities that challenge balance; poor balance in motor activities.				
3. Seeks quantities of movement including swinging, spinning, bouncing, and jumping.				
4. Difficulty or hesitance learning to climb or descend stairs.				
5. Seems to fall frequently.				
6. Gets nauseated or vomits from other movement experiences; e.g., swings, playground merry-go-rounds.				
7. Appears to be in constant motion, unable to sit still for an activity.				
Visual Perception				
1. Difficulty naming or matching colors, shapes, or sizes.				
2. Difficulty in completing puzzles; trial and error placement of pieces.				
3. Reversals in words or letters after first grade.				
4. Difficulty coordinating eyes for following a moving object; keeping place in reading; copying from blackboard to desk.				

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Does the child exhibit the following behaviors?	Yes, frequently	Sometimes	Never	Comments
Auditory/Language				
1. Appears overly sensitive to loud noises (e.g., bells, toilet flush).				
2. Is hard to understand when she or he speaks.				
3. Appears to have difficulty in understanding or paying attention to what is said to him or her.				
4. Easily distracted by sounds; seems to hear sounds that go unnoticed by others.				
5. Has trouble following 2-3 step commands.				
Emotional				
1. Does not accept changes in routine easily.				
2. Becomes easily frustrated.				
3. Difficulty getting along with other children.				
4. Apt to be impulsive, heedless, accident-prone.				
5. Easier to handle in small group or individually.				
6. Marked mood variations, tendency to outbursts or tantrums.				
7. Tends to withdraw from groups—plays on the outskirts.				
8. Has trouble making needs known in appropriate manner.				
9. Avoids eye contact.				

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Academic Difficulties:

- | | | | |
|-----------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Distractible | <input type="checkbox"/> Slow writer | <input type="checkbox"/> Following directions |
| <input type="checkbox"/> Math | <input type="checkbox"/> Restless | <input type="checkbox"/> Poorly organized | <input type="checkbox"/> Remembering information |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Finishing tasks | <input type="checkbox"/> Short attention span |

How concerned are you about the above checked problems? Not concerned Slightly Moderately Very

Questions/Comments:

Child's Name: _____ Birth Date: _____ Age: _____

Date Completed: _____ Parents' Name(s): _____ Phone: _____

Name of Case Manager/Therapist/Teacher: _____

Name of Early Intervention/Preschool: _____

Adult/Adolescent Checklist (Age Twelve and Up)

The following checklist provided by the Occupational Therapy Association - Watertown, P.C. will provide you with a very detailed evaluation of sensory integration issues. If the client demonstrates behaviors associated with sensory integration dysfunction (DSI), it may be necessary to seek further information through evaluation by a qualified occupational or physical therapist.

Child's Name: _____ Date: _____

Check areas of difficulty: underline specific problems and star (*) prominent difficulties. If child has overall difficulty in one category or shows several items in three or more categories, this may indicate a need for an occupational therapist evaluation.

Did you / do you?	Rating Scale					Examples/Comments
	5	4	3	2	1	
Sensitivity (Sensory Modulation)						
1. Blink at bright lights or seem irritated or fatigued by them?	5	4	3	2	1	
2. Become easily distracted by visual stimulation?	5	4	3	2	1	
3. Seem overly sensitive to sounds?	5	4	3	2	1	
4. Become distracted by lots of noise?	5	4	3	2	1	
5. Seek fast movement activities (e.g., hiking, skiing)?	5	4	3	2	1	
6. Avoid fast carnival rides that spin or go up and down?	5	4	3	2	1	
7. Become motion sick (e.g., in cars or airplanes)?	5	4	3	2	1	
8. Seem fearful of heights?	5	4	3	2	1	
9. React defensively or seem overly sensitive to odors (e.g., perfume, foods)?	5	4	3	2	1	
10. React defensively to the taste and texture of foods?	5	4	3	2	1	
11. Seem excessively ticklish?	5	4	3	2	1	
12. Prefer to touch rather than be touched?	5	4	3	2	1	
13. Feel bothered by clothes (eg., socks, turtlenecks, or pantyhose)?	5	4	3	2	1	
14. Avoid getting hands into messy things?	5	4	3	2	1	
15. Tend to be more sensitive to pain than others?	5	4	3	2	1	
16. Strongly dislike showers or become irritated when splashed?	5	4	3	2	1	
17. Dislike light touch from other people?	5	4	3	2	1	

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Did you / do you?	Rating Scale					Examples/Comments
Spatial and Body Awareness (Sensory Discrimination)						
1. Have difficulty looking for items on a grocery shelf?	5	4	3	2	1	
2. Have difficulty interpreting drawings in comics or cartoons?	5	4	3	2	1	
3. Have difficulty following traffic signs while driving?	5	4	3	2	1	
4. Have difficulty listening when background noise is present in a movie theater or large gathering?	5	4	3	2	1	
5. Seem to have trouble remembering or understanding what is said?	5	4	3	2	1	
6. Unable to follow two or three verbal directions given at once?	5	4	3	2	1	
7. Have difficulty learning to ride a bike?	5	4	3	2	1	
8. Have difficulty merging while driving onto a freeway?	5	4	3	2	1	
9. Have difficulties with balance?	5	4	3	2	1	
10. Get lost in new or familiar places?	5	4	3	2	1	
11. Prefer foods with strong tastes?	5	4	3	2	1	
12. Have difficulty finding objects in your pocket or purse without looking?	5	4	3	2	1	
13. Have difficulty licking an ice cream cone?	5	4	3	2	1	
14. Bump into things frequently?	5	4	3	2	1	
15. Over- or underestimate amount of force needed for a task?	5	4	3	2	1	
16. Tend to break many objects?	5	4	3	2	1	

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Did you / do you?	Rating Scale					Examples/Comments
Posture/Strength/Planning Ability						
1. Tire easily with physical activity or handwriting?	5	4	3	2	1	
2. Have difficulty sitting in class or at a meeting without excessively moving in your chair?	5	4	3	2	1	
3. Think of yourself as clumsy?	5	4	3	2	1	
4. Tend to be slow in eating?	5	4	3	2	1	
5. Have difficulty with motor tasks that have several steps?	5	4	3	2	1	
6. Take a long time to do most motor tasks; e.g., dressing?	5	4	3	2	1	
7. Have difficulty learning exercise steps or routines?	5	4	3	2	1	
Social/Emotional						
1. Tend to prefer to be alone?	5	4	3	2	1	
2. Have a strong desire for sameness and routine?	5	4	3	2	1	
3. Lack self-confidence?	5	4	3	2	1	
4. Have strong feelings of anger or rage?	5	4	3	2	1	
5. Tend to become easily frustrated?	5	4	3	2	1	
6. Have panic or anxiety attacks?	5	4	3	2	1	

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Do you have difficulty with any of the following? (Check those that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Following directions | <input type="checkbox"/> Finishing tasks |
| <input type="checkbox"/> Math | <input type="checkbox"/> Remembering information | <input type="checkbox"/> Paying attention |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Sleep | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Handwriting | <input type="checkbox"/> Recovering from stress | <input type="checkbox"/> Physical Education/Exercise class |
| <input type="checkbox"/> Organizing work | <input type="checkbox"/> Restlessness | |

Questions/Comments:

How concerned are you about the above checked problems? Not concerned Slightly Moderately Very

Name: _____ Birth Date: _____ Age: _____

Date Completed: _____ Parents' Name(s): _____ Phone: _____

Name of Case Manager/Therapist/Teacher: _____

Name of Referring agency/school: _____