**Date of assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_**

**Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reason for Assessment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Location of Assessment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**People present during assessment:**

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**Goals:** (list goals relevant to sensory assessment)

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**General Health:** (other general health conditions)

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**Social Situation:** (who does the client live with, number of siblings, any other social factors)

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**Home Environment:**

**Home ownership:**

Privately owned  Housing NSW  Private rental  (agency details): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Property details:**

House  Single storey / Two storey Unit  Town house  Villa

Length of tenure: \_\_\_\_\_\_\_\_\_\_\_

**Observations:** (light, noise, presence of clutter)

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**Informal Supports:** (include carer details relationship to client, DOB, other roles performed by carer, employment status)

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**Allied health/medical supports:** (e.g. medical specialists, behaviour support practitioner, physio, EP, speech, music therapist, dietician, psych (include provider and frequency))

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**Client’s weekly routine:** (school, work, social interactions, regular and occasional activities)

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**Sensory History:**

|  |  |
| --- | --- |
| **Likes:**  *Consider:*  *Types of food?*  *Textures?*  *Clothes?*  *Sounds?*  *Music?* |  |
| Dislikes:  *Consider:*  *Types of food?*  *Textures?*  *Clothes?*  *Sounds?*  *Music?* |  |

**Current and Previous Sensory Strategies used:** (details of strategies, how long were they used, were they successful for a period of time then no longer successful)

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**Sensory AT used by client:**

*(what AT does client currently use, what has been used successfully or unsuccessfully in the past)*

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**Behaviour During Assessment:**

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**Notes/Comments:**

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**Occupational therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_**