

Short Sensory Profile

Name

Date of Birth

This form is for adults to rate themselves through a series of questions.

Please check the box that best describes the frequency with which you show the following behaviours. Please answer all of the statements.. Please do not write in the Section Raw Score Total row.

Use the following key to mark your responses:

ALWAYS	When presented with the opportunity responds in this manner, 100% of the time.
FREQUENTLY	When presented with the opportunity frequently responds in this manner, about 75% of the time.
OCCASIONALLY	When presented with the opportunity occasionally responds in this manner, about 50% of the time.
SELDOM	When presented with the opportunity sometimes responds in this manner, 25% of the time.
NEVER	When presented with the opportunity, never responds in this manner, 0% of the time.

Tactile Sensitivity

		ALWAYS	FREQUENTLY	OCCASIONALLY	SELDOM	NEVER
1	Expresses distress during grooming (for example, fights or cries during haircutting, face washing, fingernail cutting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Prefers long-sleeved clothing when it is warm or short sleeves when it is cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Avoids going barefoot, especially in sand or grass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Reacts emotionally or aggressively to touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Withdraws from splashing water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Has difficulty standing in line or close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Rubs or scratches out a spot that has been touched	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section Raw Score Total

Taste/Smell Sensitivity

8	Avoids certain tastes or food smells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Will only eat certain tastes list	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Limits self to particular food textures/temperatures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Picky eater, especially regarding food textures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section Raw Score Total

Movement Sensitivity

		ALWAYS	FREQUENTLY	OCCASIONALLY	SELDOM	NEVER
12	Becomes anxious or distressed when feet leave the ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Fears falling or heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Dislikes activities where the head is upside down (for example, somersaults, roughhousing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Section Raw Score Total		<input type="text"/>				

Underresponsive/Seeks Sensation

15	Enjoys strange noises/seeks to make noise for noise's sake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Seeks all kinds of movement and this interferes with daily routines for example, can't sit still, fidgets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Becomes overly excitable during movement activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Touches people and objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Doesn't seem to notice when face or hands are messy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Jumps from one activity to another so that it interferes with play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Leaves clothing twisted on body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Section Raw Score Total		<input type="text"/>				

Auditory filtering

22	Is distracted or has trouble functioning if there is a lot of noise around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Appears to not hear what you say (for example, does not "tune-in" to what you say, appears to ignore you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Can't work with background noise (for example, fan, refrigerator)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Has trouble completing tasks when the radio is on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Doesn't respond when name is called but you know hearing is OK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Has difficulty paying attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Section Raw Score Total		<input type="text"/>				

Low Energy/Weak

28	Seems to have weak muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	Tires easily, especially when standing or holding particular body position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	Has a weak grasp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	Can't lift heavy objects (for example, weak in comparison to same age children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	Props to support self (even during activity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	Poor endurance/tires easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Section Raw Score Total		<input type="text"/>				

Visual/Auditory Sensitivity

		ALWAYS	FREQUENTLY	OCCASIONALLY	SELDOM	NEVER
34	Responds negatively to unexpected noises (for example, cries or hides at noise from vacuum cleaner, dog barking, hair dryer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35	Holds hands over ears to protect ears from sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36	Is bothered by bright lights after others have adapted to the light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37	Watches everyone when they move around the room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38	Covers eyes or squints to protect eyes from light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Section Raw Score Total		<input type="text"/>				

Summary

Instructions: Transfer the score for each section to the Section Raw Score Total column. Plot these totals by marking an X in the appropriate classification column (Typical Performance, Probable Difference, Definite Difference)*

Score key

- 1=Always
- 2=Frequently
- 3=Occasionally
- 4=Seldom
- 5=Never

Section	Section Raw Score Total	Typical Performance	Probable Difference	Definite Difference
Tactile Sensitivity Taste/Smell	/35	35 ____ 30	29 ____ 27	26 ____ 7
Sensitivity Movement Sensitivity	/20	20 ____ 15	14 ____ 12	11 ____ 4
Underresponsive/Seeks Sensation	/15	15 ____ 13	12 ____ 11	10 ____ 3
Auditory Filtering	/35	35 ____ 27	26 ____ 24	23 ____ 7
Low Energy/Weak	/30	30 ____ 23	22 ____ 20	19 ____ 6
Visual/Auditory Sensitivity	/30	30 ____ 26	25 ____ 24	23 ____ 6
Total	/25	25 ____ 19	18 ____ 16	15 ____ 5
	/190	190 ____ 155	152 ____ 142	141 ____ 38