Sensory summary

This will help us to accommodate your sensory needs at work and develop a sensory summary for you.

Name:	
Date:	

Please place a TICK ✓ in the column(s) that indicate how much distraction each of your senses may have on your ability to work effectively.

SENSE	Not very distracted	Some distraction	Distracts me a lot	Not sure	What makes it better? What strategies work for you?
Sight  I.e. Are you affected by odd colours, fluorescent or flickering lights?					
Sound  I.e. Are you easily distracted by noise; heightened hearing?					
Touch/texture  I.e. What touch do you avoid? For example: shaking hands, different textures/ clothes?					
Taste  I.e. Do not like textures of certain foods?					
Smell  I.e. Do you have a heightened sense of smell; distracted by perfumes or strong-smelling foods?					
Movement  I.e. Do you need to move frequently or jiggle to maintain focus?					