Sensory Room
Recording and Monitoring Form

Name: ________________

Facilitator:	____________________	**Date:**	______________
Birthday:	____________________	Time of day:	______________
Visit #:	____________________	Time in Sensory Room:	______________
Diagnosis:	____________________	Position for activities:	______________
		(sitting, lying, mobile)	
	____________________		______________
Medications:	____________________		______________
	____________________		______________
Likes:	____________________	Dislikes:	______________
	____________________		______________

Sensory room goal reminder: to provide an environment that is calming and stimulating, that encourages independent exploration, relaxation and increases attention and self-awareness.

Objective: check all that apply

a. Improve communication	______	i. Develop interactive skills	______
b. Develop sensory awareness	______	j. Stimulate motivation	______
c. Develop body awareness	______	k. Promote relaxation	______
d. Make choices	______	l. Reduce stress	______
e. Develop cause and effect	______	m. Relationship building	______
f. Anger control	______	n. Reduce problem behaviour	______
g. Interact with peers	______	o. Interact with staff	______
h. Other ______________________	______	p. Other ______________________	______

General observation of behavioural change or issues
Please note, changes may be noted during the session, immediately after or for several days after.

Positive ____________ No change ____________ Negative ____________

Additional comments:

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Equipment used

	Yes	No	If yes, how long	Comments
Bubble tube large				
Bubble tube small				
Wall light spray				
Corner light spray				
Green stars on wall				
Spotlight on disco ball				
Rotating picture on wall				
Music				
Flat swing				
Hammock swing				
Vibrating pillow				
Interactive colour buttons				
Interactive colour cube				
Scents				
Trampoline				
Black light				
Other:				
Other:				

Please report any equipment concerns to the Autism Yukon Staff. Thank you!