QST Sense and Self-Regulation Checklist

Instructions:

1. Before beginning Qigong Sensory Training therapy with your child, complete the form on the following two pages.
2. Write the date, name of your child, and who is completing the checklist. (It is very important that the same parent/caretaker complete the form each time the form is used.)
3. Circle the response for each item that most accurately describes your child.
4. Add all of the numbers circled.
5. Write total into the space provided.

After using Qigong Sensory Training therapy on your child once a day for five months, have the same parent complete the form again. Total numbers circled.

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Date: _____ Name of child: _____ Name of person completing checklist:_____

QST Sense and Self-Regulation Checklist

Please circle the response for each item that most accurately describes your child.	**Often**	**Sometimes**	**Rarely**	**Never**
1. TOUCH/PAIN				
• Does not cry tears when hurt	3	2	1	0
• Doesn't notice if the diaper is wet or dirty	3	2	1	0
• Face washing is difficult	3	2	1	0
• Haircuts are difficult	3	2	1	0
• Refuses to wear a hat	3	2	1	0
• Prefers to wear a hat	3	2	1	0
• Cutting fingernails is difficult	3	2	1	0
• Prefers to wear one or two gloves	3	2	1	0
• Avoids wearing gloves	3	2	1	0
• Cutting toenails is difficult	3	2	1	0
• Will only wear certain footwear (e.g. loose shoes, no socks)	3	2	1	0
• Prefers to wear the same clothes day after day	3	2	1	0
• Will only wear certain clothes (e.g. no elastic, not tight, no tags, long or short sleeves)	3	2	1	0
• Cries tears when falls, scrapes skin, or gets hurt (scale is reversed on purpose)	0	1	2	3
• Head bangs on a hard surface	3	2	1	0
• Head bangs on a soft surface	3	2	1	0
Self-regulation – Orientation/Attention/Self-soothing/Sleep	**Often**	**Sometimes**	**Rarely**	**Never**
• Has to be prompted to make eye contact when spoken to	3	2	1	0
• Seems not to notice when spoken to in a normal voice	3	2	1	0
• Does not respond to his/her name	3	2	1	0
• Does not notice or react when tapped on the back	3	2	1	0
• Does not roll over onto the back when asked	3	2	1	0
• Stares off into space	3	2	1	0
• Seems unaware when others are hurt	3	2	1	0
• Has difficulty calming him/herself when upset	3	2	1	0
• Gets upset or tantrums when asked to make a transition	3	2	1	0
• Has difficulty falling asleep at bedtime	3	2	1	0
• Has difficulty falling back asleep when awakens during the night	3	2	1	0
• Awakens very early and stays awake	3	2	1	0
• Has difficulty awakening in morning	3	2	1	0
• Makes little jokes. *(Answer only if your child has language.)* (scale is reversed on purpose)	0	1	2	3
2. VISION	**Often**	**Sometimes**	**Rarely**	**Never**
• Looks at objects out of sides of eyes	3	2	1	0
• Is bothered by certain lights	3	2	1	0
Self-regulation – Behavior: Irritability, Aggression, Self-injurious	**Often**	**Sometimes**	**Rarely**	**Never**
• Tantrums or meltdowns (Tantrums last _____ minutes, and occur _____ times/day)	3	2	1	0
• Cries easily when frustrated	3	2	1	0

Please circle the response for each item that most accurately describes your child.	Often	Sometimes	Rarely	Never
• Hits or kicks others	3	2	1	0
• Scratches or pulls other's hair	3	2	1	0
• Bites others	3	2	1	0
• Throws things at others	3	2	1	0
• Pulls own hair (Where on the head?)	3	2	1	0
• Bites self (Which part of the body e.g. left thumb?)	3	2	1	0
• Hits self (Which part of the body?)_____	3	2	1	0
• Gets aggressive or 'hyper' with exposure to certain smells	3	2	1	0

3. HEARING

• Reacts poorly to certain everyday noises	3	2	1	0
• Covers ears with certain sounds	3	2	1	0
• Reacts strongly when others cry loudly or scream	3	2	1	0
• Is startled by sudden noises	3	2	1	0
Self-regulation – Toilet Training	**Often**	**Sometimes**	**Rarely**	**Never**
• Is dry at night (scale is reversed on purpose)	0	1	2	3
• Diaper is wet in the morning	3	2	1	0
• Wears a diaper during the day	3	2	1	0
• Is toilet trained (scale is reversed on purpose)	0	1	2	3
4. TASTE/SMELL:	**Often**	**Sometimes**	**Rarely**	**Never**
• Gags with certain smells	3	2	1	0
• Avoids foods with certain textures	3	2	1	0
• Tooth brushing is difficult	3	2	1	0
• Mouths or chews objects	3	2	1	0
Self-regulation - Digestion	**Often**	**Sometimes**	**Rarely**	**Never**
• Will only eat familiar foods	3	2	1	0
• Does not seem to be interested in food	3	2	1	0
• Eats very few foods (five to ten items)	3	2	1	0
• Bowels are loose	3	2	1	0
• Bowel movements ("poops") are frequent (more than 3 per day)	3	2	1	0
• Requires regular use of laxative to avoid constipation	3	2	1	0
• Bowel movement ("poop") is hard and dry	3	2	1	0
• Has a bowel movement every other day	3	2	1	0
• Has a bowel movement twice a week	3	2	1	0
• Has a bowel movement once a week	3	2	1	0
• Bowel movements are often green	3	2	1	0

Total _____

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