|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |
| --- | --- | --- |
| **Pupil:** | **School:** | **Previous school(s)** |
| **Birth history/early milestones:** *e.g. Pre term (how many weeks?), medical interventions, difficulties during pregnancy/crawling/walking/toileting/* | **Communication:** *e.g. non-verbal, echolalic, unusual tone or pitch, difficulty understanding verbal directions, can the pupil initiate communication, literal interpretation* | **Sensory Processing difficulties:** *e.g. struggles with noises, certain smells or textures and /or information overload* | **Compulsivity and Change:** *e.g. problems with change, compulsive or driven behaviours, obsessive thoughts, management of/need for routines and consistent strategies* |
| **Social difficulties:** *e.g. prefers to be alone, difficulty with joint attention, difficulty in interpreting non-verbal cues, difficulties relating to others* | **Behavioural. Emotional and****Mental Health:** *e.g. forms of anxiety - self-harm, low mood, self-excluding, tense, unable to make a decision, food concerns* | **Details and Concepts:** *difficulties focussing on details, inability to identify relevant from irrelevant, concrete thinking, problems with abstract thinking* | **Organisation and life skills:** *problems with sequencing routines, following multi-step instructions, personal hygiene (toileting, brushing teeth, showering)* |

**Overview of Needs** |
| **Name of person completing form: Relationship to pupil: Date:** |

**NB: Please also complete and return the Sensory Checklist**