Ministry of Health
Occupational Therapy Department

Patient Name: _____ File Number: _____

SENSORY SCREENING SHEET

Sensory Evaluation	Left	Right	Comments
1. Superficial Sensation A. Light Touch/ Pressure			
B. Pain Sharp			
Dull			
C. Temperature			
2. Deep Sensation A. Proprioception			
B. Kinesthesia			
C. Tactile Localization			
D. Vibration			
3. Mixed Sensation A. Stereognosis			
B. Graphasthesia			

Key	
NT	Not Tested
0	Absent, No Response
1	Decreased, Delayed Response
2	Increased, Exaggerated Response
3	Inconsistent Response
4	Intact, Normal Response

Therapist Signature: _____ **Date:** _____