Sensory Room Questionnaire

Your Name:_____

Organization:_____

Phone Number:_____

Email Address:_____

Room Information

Describe the individual(s) who will be using the room (age, sensory needs, accessibility needs, etc)

_____

_____

_____

_____

_____

How many individuals with special needs and caregivers will use the room at one time?

_____

Purpose (check all that apply)

☐ Motor Activity ☐ Socialization

☐ Calming ☐ Stimulation

☐ Organization ☐ Play

Senses on which to focus (check all that apply)

☐ Visual Sense ☐ Proprioception

☐ Tactile Sense ☐ Vestibular Sense

☐ Auditory Sense ☐ Olfactory Sense (Smell)

☐ Gustatory Sense (Taste)

Submit this form via email at info@got-specialkids.com or Fax to 513-881-7010

Layout (Please attach a sketch and/or photos if possible)

Size of Room: Length:_____

Width:_____

Ceiling height in the room:_____

Ceiling Type: ☐ Drop Ceiling ☐ Dry Wall Ceiling

Wall Type: ☐ Dry Wall ☐ Concrete or Block ☐ Brick ☐ Other_____

Are there windows in the room? ☐ Yes ☐ No

Describe any blinds, shades, or curtains covering the windows:

_____

_____

Equipment

Do you already own any equipment that you would like included in the room? _____

_____

_____

Got-Autism/Got-Special Kids works with a variety of manufacturers to meet our customers' needs. Are there specific items you have in mind for your room? _____

_____

_____

Pricing

What is your budget? _____

Do you plan to apply for grants/outside funding? _____

When would you like the room to be completed? _____

Additional Information

_____

_____

_____

_____

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