



# BUILD YOUR SENSORY ROOM *with* FREE QUOTES AND DESIGN SERVICES

## ROOM CONCEPT

Briefly describe your Sensory Room Concept

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## PURPOSE/OBJECTIVE FOR SENSORY ROOM (check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Active Play   | <input type="checkbox"/> Focus         | <input type="checkbox"/> Soft Play                                   |
| <input type="checkbox"/> Calming       | <input type="checkbox"/> Relaxation    | <input type="checkbox"/> Stimulation                                 |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Socialization | <input type="checkbox"/> Visual <input type="checkbox"/> Kinesthetic |
|  |  | <input type="checkbox"/> Auditory <input type="checkbox"/> Tactile   |

## POPULATION SERVED

What are the developmental needs of the children and/or teens who will use the Sensory Room and/or Break Boxes! (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> Behavior Issues        | <input type="checkbox"/> Sensory Integration    |
| <input type="checkbox"/> Auditory Processing      | <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Social Skills          |
| <input type="checkbox"/> Autism                   | <input type="checkbox"/> Communication/Language | <input type="checkbox"/> Other - please specify |
| <input type="checkbox"/> Balance and Coordination | <input type="checkbox"/> Down Syndrome          | _____   |

What are the age ranges? \_\_\_\_\_

Do you need to accommodate wheelchair users? Yes \_\_\_ No \_\_\_

How many students do you expect will use the Sensory Room at the same time? 1-2 \_\_\_ 3-4 \_\_\_ more than 4 \_\_\_



**FLOOR PLAN - Please attach room schematic if available**

Length x Width of Room \_\_\_\_\_ Length x Width of Doorway \_\_\_\_\_  
Ceiling Height \_\_\_\_\_ Type of Ceiling \_\_\_\_\_ Floor Covering \_\_\_\_\_  
Location of doors & windows \_\_\_\_\_

**BUDGET AND TIMING**

Budget Range \_\_\_\_\_  
What's your time frame for creating the Sensory Room? \_\_\_\_\_  
When do you need this quote? \_\_\_\_\_  
Anticipated Order Date \_\_\_\_\_  
Any specific products that are must-haves?

\_\_\_\_\_  
\_\_\_\_\_

Any specific products that you do not want?

\_\_\_\_\_  
Any suggestions for new sensory products that we should develop? \_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONTACT INFO**

Your Name \_\_\_\_\_  
Your Role \_\_\_\_\_  
Name of your school or organization \_\_\_\_\_ Tax Exempt? Yes \_\_\_ No \_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Fax \_\_\_\_\_ Best time to reach you \_\_\_\_\_

Please email the completed form to [karen.obrien@enablingdevices.com](mailto:karen.obrien@enablingdevices.com) or via fax 1-914-747-3480. We will respond within one or two business days.

