

**Screener**: Rita Eissmann

**Contact Information:**

* **Phone**: (775) 413 - 9191
* **Email:** irlenofreno@gmail.com

Please fill out this form. Parent, complete the form in co-operation with your child.

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Grade**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**:\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed by**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE: YOUR EXPERIENCES CAN BE IN THE PAST,  
WHEN IN SCHOOL, AS WELL AS THE PRESENT.**

|  |  |
| --- | --- |
| **Are you light sensitive?** | **Types of reading difficulties:** |
| **Bothered by sunlight**   * Yes * No   **Bothered by glare**   * Yes * No   **Do you frequently wear sunglasses**   * Yes * No   **Bothered by bright or fluorescent lights**   * Yes * No   **Tired or drowsy under bright or fluorescent lights**   * Yes * No   **Become anxious under bright or fluorescent lights**   * Yes * No   **Get a headache/stomachache from bright or fluorescent lights**   * Yes * No   **Feel antsy or fidgety under bright or fluorescent lights**   * Yes * No   **Harder to listen under bright or fluorescent lights**   * Yes * No   **Performance deteriorates under bright or fluorescent lights**   * Yes * No   **Feel like there is not enough light when reading**   * Yes * No   **Feel like there is too much light when reading**   * Yes * No   **Read in dim light**   * Yes * No   **Shade the page with your hand or body**   * Yes * No | **Skip words or lines**   * Yes * No   **Repeat or reread lines**   * Yes * No   **Read with breaks**   * Yes * No   **Lose place**   * Yes * No   **Read in a “stop and go” rhythm**   * Yes * No   **Omit small words**   * Yes * No   **Poor reading comprehension**   * Yes * No   **Reading becomes harder the longer you read**   * Yes * No   **Use your finger or marker to help keep your place**   * Yes * No   **Avoid reading**   * Yes * No   **Avoid reading for pleasure**   * Yes * No   **Rereads for comprehension**   * Yes * No   **Reversals of letters and/or numbers**   * Yes * No |
| **While reading or using a computer, do you:** | **Do you feel strain, fatigue, tired, or have headaches when:** |
| **Rub eyes**   * Yes * No   **Move closer to or further away**   * Yes * No   **Squint**   * Yes * No   **Open eyes wide**   * Yes * No   **Incorporate breaks**   * Yes * No   **Change position to reduce glare**   * Yes * No   **Close or cover one eye**   * Yes * No   **Move head**   * Yes * No   **Read word by word**   * Yes * No   **Unable to speed read**   * Yes * No | **Reading**   * Yes * No   **Listening**   * Yes * No   **Doing paper and pencil tasks**   * Yes * No   **Reading on the computer / iPad / iPhone / Tablet**   * Yes * No   **Watching TV, movies, or live stage productions**   * Yes * No   **Copying material**   * Yes * No   **Doing math assignments**   * Yes * No   **Playing video games**   * Yes * No   **Writing essays**   * Yes * No   **Doing visually intensive activities like needlepoint, sewing, cross stitching, crossword puzzles, woodworking, soldering, etc.**   * Yes * No   **Reading under bright or fluorescent lights**   * Yes * No   **Looking at stripes, patterns, polka dots, fluorescent colors**   * Yes * No |
| **Handwriting:** | **Attention/Concentration:** |
| **Write up or down hill**   * Yes * No   **Unequal or no spacing between letters or words**   * Yes * No   **Unequal letter size**   * Yes * No   **Unable to write on the line**   * Yes * No   **Leave out words, letters, or punctuation marks**   * Yes * No | **Problems concentrating with reading or writing**   * Yes * No   **Easily distracted when reading or writing**   * Yes * No   **Easily distracted when listening**   * Yes * No   **Easily distracted when taking tests**   * Yes * No   **Daydreams in class or at lectures**   * Yes * No   **Problems staying on task**   * Yes * No   **Problems starting tasks**   * Yes * No   **Difficulty with scantron answer sheets**   * Yes * No |
| **Copying:** | **Composition/Essay Writing:** |
| **Lose place (book, chalkboard, whiteboard, overhead)**   * Yes * No   **Leave out words (book, chalkboard, whiteboard, overhead)**   * Yes * No   **Slow (book, chalkboard, whiteboard, overhead)**   * Yes * No   **Incomplete (book, chalkboard, whiteboard, overhead)**   * Yes * No   **Careless errors (book, chalkboard, whiteboard, overhead)**   * Yes * No   **Blink or squint (book, chalkboard, whiteboard, overhead?**   * Yes * No   **Difficulty refocusing**   * Yes * No   **Difficulty copying things onto or off computer or typewriter**   * Yes * No | **Disorganized**   * Yes * No   **Problems with punctuation**   * Yes * No   **Problems proofreading**   * Yes * No   **Leave out letters or words**   * Yes * No   **Write without rereading**   * Yes * No |
| **Mathematics:** | **Music:** |
| **Misalign digits in number columns**   * Yes * No   **Difficulty seeing numbers in the correct column**   * Yes * No   **Sloppy or careless errors**   * Yes * No   **Use finger, graph paper, or other marker when working with columns of numbers**   * Yes * No   **Difficulty seeing signs, symbols, numbers, decimal points**   * Yes * No   **Reversals of numbers**   * Yes * No | **Problems sight reading the notes**   * Yes * No   **Prefer to memorize rather than read music**   * Yes * No   **Prefer to play by ear**   * Yes * No   **Use finger to track notes**   * Yes * No   **Lose your place**   * Yes * No   **Trouble reading the notes or notes and words together**   * Yes * No   **Difficulty interpreting the music notations**   * Yes * No   **Little progress in spite of regular practice**   * Yes * No |
| **Depth Perception:** | **Sports Performance:** |
| **Difficulty getting on and off escalators**   * Yes * No   **Clumsy**   * Yes * No   **Bump into table edges or door jams**   * Yes * No   **Difficulty walking up and/or downstairs**   * Yes * No   **Difficulty judging distances**   * Yes * No   **Drop or knock things over**   * Yes * No   **As a child, accident prone or have bruises on your shins**   * Yes * No   **When walking next to someone, do you drift into the person**   * Yes * No   **When walking, do you feel dizzy or lightheaded**   * Yes * No   **Afraid of heights**   * Yes * No | **Problems tracking a flying ball like golf, baseball, or tennis**   * Yes * No   **Trouble following the ball when watching sports on TV such as tennis, football or basketball**   * Yes * No   **When watching sports on TV, can you follow the ball but not see anything else**   * Yes * No   **Trouble catching or hitting a ball**   * Yes * No   **Difficulty playing pool**   * Yes * No   **Difficulty hitting the ball when playing baseball or tennis**   * Yes * No   **Trouble learning how to ride a bike**   * Yes * No   **Trouble jumping rope? Jump in at the wrong time or jump into the rope**   * Yes * No   **Trouble playing games such as volleyball or four square**   * Yes * No   **On playground equipment such as rings or bars, was it hard to go from one to the other**   * Yes * No |
| **Driving:** | **Fatigue While in A Car:** |
| **Difficulty parallel parking**   * Yes * No   **Do you feel like you will hit the car in front when parking**   * Yes * No   **When parking, do you hit the curb or leave too much space**   * Yes * No   **Difficulty judging when to turn in front of oncoming traffic**   * Yes * No   **Uncertain about making lane changes**   * Yes * No   **Extra cautious when making lane changes**   * Yes * No   **Are the passengers tense when you make lane changes**   * Yes * No   **Do passengers tell you that you tailgate**   * Yes * No   **Are you overly cautious, leaving extra room between you and the car ahead**   * Yes * No | **As a passenger, do you become drowsy**   * Yes * No   **When driving, do you become drowsy**   * Yes * No   **Bothered by glare on the chrome on cars**   * Yes * No   **Bothered by glare off the rear window of the car in front of you**   * Yes * No   **Stressful to drive in the rain/snow (glare)**   * Yes * No   **Avoid driving at night**   * Yes * No   **Bothered by headlights and streetlights at night**   * Yes * No   **Bothered by taillights on cars**   * Yes * No   **Bothered by red/green traffic lights**   * Yes * No   **Have night blindness**   * Yes * No |