

**Screener**: Rita Eissmann

**Contact Information:**

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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
 |