SELF-TEST FOR IRLEN SYNDROME (SPD)

(WWW.AOTSS.COM)

SCAN AND EMAIL THIS FOR TO INFO@AOTSS.COM OR FAX TO(443) 460-2275

Please fill out this form. Parents, please complete this form in cooperation with your child.

Name _____ Age _____ Grade _____

Profession_____ Degrees: _____

Address _____ Cell# _____

City _____ State_____ Zip Code _____

Completed by _____ Date _____

Email Address: _____ Relationship to Client: _____

Client has had an Irlen Screening: ____YES ____NO Date/Screener: _____

Submit results of Irlen Screening to info@aotss.com for review prior to Irlen Diagnostic Testing

Name of Parents or Guardians: _____

Contact info or Parent or Guardian if different from client:

CHARACTERISTIC ____ADULT CLIENT ____/____CHILD/AGE _____PARENT
Please Circle Answer: Have client respond with either YES, NO or ?/ Parent Y (YES)

Are you light sensitive?

Bothered by sunlight	Yes	No	?	Y
Bothered by glare	Yes	No	?	Y
Frequently wear sunglasses	Yes	No	?	Y
Bothered by bright or fluorescent lights	Yes	No	?	Y
Tired or drowsy under bright or fluorescent lights	Yes	No	?	Y
Becomes anxious under bright or fluorescent lights	Yes	No	?	Y
Get headaches/stomachaches from bright or fluorescent lights	Yes	No	?	Y
Feels antsy or fidgety under bright or fluorescent lights	Yes	No	?	Y
Difficulty listening when under bright or fluorescent?	Yes	No	?	Y
Performance deteriorate under bright/fluorescent lights	Yes	No	?	Y
Feels like there is not enough light when reading	Yes	No	?	Y
Fees like there is too much light when reading	Yes	No	?	Y
Prefers to read in a dim light or dark room	Yes	No	?	Y
Uses finger, ruler, or marker to block out lines or parts of the page	Yes	No	?	Y
Shade the page with your hand or body when reading	Yes	No	?	Y
Bothered by glare on your computer monitor or phone	Yes	No	?	Y
One eye is more sensitive to light then the other eye	Yes	No	?	Y
Neurological tics are worse under bright or fluorescent lights	Yes	No	?	Y

Additional comments:

Problems when reading text or using a computer monitor:

Skips words or lines	Yes	No	?	Y
Repeats or rereads lines	Yes	No	?	Y
Read for less than one hour	Yes	No	?	Y
Lose place	Yes	No	?	Y
Read in a “stop and go” rhythm aloud or word for word	Yes	No	?	Y
Omit small words	Yes	No	?	Y
Substitutes words or guesses	Yes	No	?	Y
Problem understanding what you read	Yes	No	?	Y
Rereads what you read to understand	Yes	No	?	Y
Reading becomes harder the longer you read	Yes	No	?	Y
Avoids reading	Yes	No	?	Y
Avoids reading for pleasure	Yes	No	?	Y
Reverses letters and/or numbers	Yes	No	?	Y
Misreads words or numbers	Yes	No	?	Y
Takes longer to read then others in class	Yes	No	?	Y
Takes longer to complete assignments then others	Yes	No	?	Y
Takes frequent breaks while reading	Yes	No	?	Y
Reading is easier at home or in a quiet space	Yes	No	?	Y
Reads very slowly	Yes	No	?	Y
Squints or opens eyes wide when reading	Yes	No	?	Y
Rubs eyes when reading	Yes	No	?	Y
Sees more clearly with one eye over the other	Yes	No	?	Y
Closes or covers one eye during reading	Yes	No	?	Y
Holds head too close/far away to book or computer screen	Yes	No	?	Y
Poor posture or tilts body when reading	Yes	No	?	Y
Changes position to reduce glare	Yes	No	?	Y
Headaches after reading or computer work	Yes	No	?	Y
Double vision when reading	Yes	No	?	Y
Blurry letters even with RX glasses and gets worse as you read	Yes	No	?	Y
Letters/numbers have halos, shake, move, reverse, vibrate, or shift	Yes	No	?	Y
Page or letters glitter, glow, float, jump, pulse, or swim	Yes	No	?	Y
Lines or words run together, or white spaces are distracting	Yes	No	?	Y
Letters, numbers or lines disappear and comeback	Yes	No	?	Y
Problems with directionality	Yes	No	?	Y
Gets nauseous or carsick when reading or working at computer	Yes	No	?	Y
Rub your eyes	Yes	No	?	Y
Unable to speed read	Yes	No	?	Y

Additional comments:

Do you feel strain, fatigue, tired, or have headaches when?

Reading	Yes	No	?	Y
Listening	Yes	No	?	Y
Writing	Yes	No	?	Y
Working on the computer	Yes	No	?	Y
Copying from a book	Yes	No	?	Y
Copying from a PowerPoint or black/whiteboard	Yes	No	?	Y
Writing essays or long assignments	Yes	No	?	Y

Calculation or completing math assignments	Yes	No	?	Y
Watching TV, movies	Yes	No	?	Y
Playing video games	Yes	No	?	Y
Doing visually-intensive activities like needlepoint, sewing, cross stitching, crossword puzzles, woodworking, soldering, etc.	Yes	No	?	Y
Working under bright or fluorescent lights	Yes	No	?	Y
Looking at stripes, patterns, bright colors, and high contrast	Yes	No	?	Y

Attention/Concentration:

Problems concentrating with reading or writing	Yes	No	?	Y
Problems maintaining focus	Yes	No	?	Y
Easily distracted when reading or writing	Yes	No	?	Y
Easily distracted when listening	Yes	No	?	Y
Response is delayed during class participation or conversation	Yes	No	?	Y
Easily distracted when taking tests	Yes	No	?	Y
Distracted by environmental sounds (HVAC, people, etc.	Yes	No	?	Y
Bothered by clothing texture and tightness	Yes	No	?	Y
Daydreams in class or at lectures or loses awareness	Yes	No	?	Y
Problems staying on task	Yes	No	?	Y
Problems starting tasks	Yes	No	?	Y
Difficulty with scantron answer sheets	Yes	No	?	Y
Diagnosed/medication for ADD or ADHD	Yes	No	?	Y
Confuses right and left and following directions	Yes	No	?	Y
Difficulty following verbal directions	Yes	No	?	Y
Understanding increases with 1 or more sensory system is used	Yes	No	?	Y

Types of Learning Styles: visual, auditory, tactile/kinesthetic, olfactory, taste, movement (circle one)

Additional Comments:

Problems with Handwriting:

Writes up or down hill	Yes	No	?	Y
Unequal or no spacing between letters or words	Yes	No	?	Y
Unequal letter size	Yes	No	?	Y
Unable to write on the line or designated area (above/below)	Yes	No	?	Y
Incorrect or inefficient letter formation	Yes	No	?	Y
Needs to verbalize what is being written	Yes	No	?	Y
Leaves out words, letters, or punctuation marks	Yes	No	?	Y
Inconsistent letter formation and legibility	Yes	No	?	Y
Misaligns lines or paragraphs	Yes	No	?	Y
Reverses letters or words	Yes	No	?	Y
Avoids writing	Yes	No	?	Y
Poor posture while writing	Yes	No	?	Y
Inconsistent writing hand (lacks dominance)	Yes	No	?	Y
Poor or inefficient grasp of writing implement	Yes	No	?	Y
Inconsistently or does not stabilize paper while writing	Yes	No	?	Y
Becomes tired when writing, muscle fatigue	Yes	No	?	Y

Hand hurts when writing	Yes	No	?	Y
Writes too big or small relative to others of same age	Yes	No	?	Y
Becomes fidgety or restless when writing	Yes	No	?	Y
Prefers to print when writing	Yes	No	?	Y
Unable to write or read cursive writing	Yes	No	?	Y
Prefers to use the keyboard instead f handwriting	Yes	No	?	Y
Complains of glare when writing on white paper	Yes	No	?	Y

Additional Comments:

Copying:

Lose place (book, chalkboard, whiteboard, overhead)	Yes	No	?	Y
Leave out words (book, chalkboard, whiteboard, overhead)	Yes	No	?	Y
Slow (book, chalkboard, whiteboard, overhead)	Yes	No	?	Y
Incomplete (book, chalkboard, whiteboard, overhead)	Yes	No	?	Y
Careless errors (book, chalkboard, whiteboard, overhead)	Yes	No	?	Y
Blink or squint (book, chalkboard, whiteboard, overhead?	Yes	No	?	Y
Difficulty refocusing	Yes	No	?	Y
Difficulty copying things onto or off computer or PowerPoint	Yes	No	?	Y

Additional Comments:

Composition/Essay Writing:

Disorganized	Yes	No	**?**	**Y**
Problems with punctuation	Yes	No	?	Y
Problems proofreading	Yes	No	?	Y
Leaves out letters or words	Yes	No	?	Y
Does not understand or remember what is written	Yes	No	?	Y

Additional Comments:

Mathematics:

Misalign digits in number columns	Yes	No	?	Y
Difficulty seeing numbers in the correct column	Yes	No	?	Y
Sloppy or careless errors	Yes	No	?	Y
Uses finger, graph paper, or other marker when working with columns of numbers	Yes	No	?	Y
Difficulty seeing signs, symbols, numbers, decimal points	Yes	No	?	Y
Reversals of numbers	Yes	No	?	Y

Additional Comments:

Music:

Problems sight reading the notes	Yes	No	?	Y
Prefer to memorize rather than read music	Yes	No	?	Y
Prefer to play by ear	Yes	No	?	Y
Use finger to track notes	Yes	No	?	Y
Lose your place	Yes	No	?	Y
Trouble reading the notes or notes and words together	Yes	No	?	Y
Difficulty interpreting the music notations	Yes	No	?	Y
Little progress in spite of regular practice	Yes	No	?	Y

Additional Comments:

Depth Perception:

Difficulty getting on and off escalators	Yes	No	?	Y
Clumsy	Yes	No	?	Y
Bump into table edges or door jams	Yes	No	?	Y
Difficulty walking up and/or downstairs	Yes	No	?	Y
Difficulty judging distances	Yes	No	?	Y
Drop or knock things over	Yes	No	?	Y
As a child, accident prone or have bruises on your shins	Yes	No	?	Y
When walking next to someone, do you drift into the person	Yes	No	?	Y
When walking, do you feel dizzy or lightheaded	Yes	No	?	Y
Difficulty getting on or off moving objects	Yes	No	?	Y

Additional Comments:

Driving:

Difficulty parallel parking	Yes	No	?	Y
Do you feel like you will hit the car in front when parking	Yes	No	?	Y
When parking, do you hit the curb or leave too much space	Yes	No	?	Y
Difficulty judging when to turn in front of oncoming traffic	Yes	No	?	Y
Uncertain about making lane changes	Yes	No	?	Y
Extra cautious when making lane changes	Yes	No	?	Y
Passengers tense when you make lane changes	Yes	No	?	Y
Passengers tell you that you tailgate	Yes	No	?	Y
Overly cautious	Yes	No	?	Y
Maintains extra room between you and the car ahead	Yes	No	?	Y

Additional Comments:

Sports Performance:

Problems tracking a flying ball like golf, baseball, or tennis	Yes	No	?	Y
Trouble following the ball when watching sports on TV (tennis, football or basketball)	Yes	No	?	Y
Follows the ball when watching sports on TV, unable to see around	Yes	No	?	Y
Trouble catching or hitting a ball	Yes	No	?	Y
Difficulty playing pool	Yes	No	?	Y
Difficulty hitting the ball when playing baseball or tennis	Yes	No	?	Y
Trouble learning how to ride a bike	Yes	No	?	Y
Trouble jumping rope?	Yes	No	?	Y
Jumps in at the wrong time or jumps into the rope	Yes	No	?	Y

Trouble playing games such as volleyball or four square	Yes	No	?	Y
Difficulty moving bar/ring to bar/ring on playground equipment	Yes	No	?	Y

Additional Comments:

Fatigue While in A Car:

As a passenger, do you become drowsy	Yes	No	?	Y
When driving, do you become drowsy	Yes	No	?	Y
Bothered by glare on the chrome on cars	Yes	No	?	Y
Bothered by glare off the rear window of the car in front of you	Yes	No	?	Y
Bothered by headlights and streetlights at night	Yes	No	?	Y
Avoid driving at night	Yes	No	?	Y
Have night blindness	Yes	No	?	Y
Bothered by taillights on cars	Yes	No	?	Y
Bothered by red/green traffic lights	Yes	No	?	Y
Stressful to drive in the rain (glare)	Yes	No	?	Y

Additional Comments:

Sensory Processing Disorder Symptoms:

Difficulty falling and/or staying asleep	Yes	No	?	Y
Strong outbursts of anger	Yes	No	?	Y
Bumps into or pushes others	Yes	No	?	Y
Frequently drops or knocks over things	Yes	No	?	Y
Mouths, licks, chews or sucks non-food items	Yes	No	?	Y
Craves movement like spinning or swinging	Yes	No	?	Y
Afraid of heights, slides, bridges	Yes	No	?	Y
Poor balance and coordination	Yes	No	?	Y
Difficulty going up/downstairs or uneven ground	Yes	No	?	Y
Skipped or short crawling phase as toddler	Yes	No	?	Y
Seams weaker than other children of same age	Yes	No	?	Y
Difficulty making eye contact, tracking with eyes	Yes	No	?	Y
Difficulty following multi-step directions	Yes	No	?	Y
Difficulty with transitions – need for strict routine	Yes	No	?	Y
Difficulty taking turns and/or playing with others	Yes	No	?	Y
Difficulty standing in line or waiting for next activity	Yes	No	?	Y
Difficulty dressing self or bathroom activities	Yes	No	?	Y
Dislikes textures and/or tastes of most foods	Yes	No	?	Y
Difficulty applying new learning to different situations	Yes	No	?	Y
Complains excessively and has negative attitude	Yes	No	?	Y
Strong dislike of specific smells, tastes, food textures	Yes	No	?	Y
Strong dislike for specific textures of clothing, sox, shoes	Yes	No	?	Y
Strong reaction to sounds, environmental stimuli	Yes	No	?	Y

Dislike of holding, hugging, physical contact	Yes	No	?	Y
Resists tooth/hair brushing, bathing, face washing	Yes	No	?	Y
Frequent ear infections as baby	Yes	No	?	Y
Frequent ear infections through childhood	Yes	No	?	Y
Avoids social situations, dislikes physical contact	Yes	No	?	Y
Mouths objects or, bites nails etc.	Yes	No	?	Y
Avoids midline crossing, uses one hand at a time	Yes	No	?	Y
Confuses right and left, no dominant hand	Yes	No	?	Y
Decreased pain tolerance or emotionally sensitive	Yes	No	?	Y
Extreme fatigue, overwhelmed easily	Yes	No	?	Y

Additional Comments:

Date of Last Eye Exam: _____
Client wears RX glasses for the following: ___near vision ___distance ___both
___bifocal/progressive _____RX sunglasses/color _____PLANO sunglasses/color

Do/Did you receive any of the following support services (circle the appropriate ones)?
Past: OT, PT, TUTORING, COUNSELING, THERAPY, VISION THERAPY
Present: : OT, PT, TUTORING, COUNSELING, THERAPY, VISION THERAPY

If you answered yes to three or more questions in any one of the above symptom categories, then you might be experiencing the effects of a perception problem called Irlen Syndrome or Scotopic Sensitivity.
If a category is not applicable to your situation or issues: cross it out and mark N/A . Please send as a printable document either by email or fax. No photos or poorly scanned documents with dark, gray or colored background.

For further information, contact:
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Additional Comments: ___Client or ___Parent/Guardian or ___Both (check one or more)