

The Irlen Self Test

Client name:

DOB:

Parent/Guardian:

Address:

Telephone:

School:

College:

University:

Do you have a Special Educational Need or Disability? Yes / No

If Yes, please specify:

*Please discuss with me if you have Autism Spectrum Disorder (ASD) as an alternative Self Test may be more beneficial.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you light sensitive: | Yes/ Often | Yes/ Sometimes | No/ Never | Notes:  |
| 1. Bothered by sunlight
 |  |  |  |  |
| 1. Bothered by glare
 |  |  |  |  |
| 1. Do you frequently wear sunglasses or a hat
 |  |  |  |  |
| 1. Bothered by bright or fluorescent lighting
 |  |  |  |  |
| 1. Tired or drowsy under bright or fluorescent lighting
 |  |  |  |  |
| 1. Become anxious under bright or fluorescent lighting
 |  |  |  |  |
| 1. Get a headache/stomach ache under bright or fluorescent lighting
 |  |  |  |  |
| 1. Feel distracted or fidgety under bright or fluorescent lighting
 |  |  |  |  |
| 1. Harder to listen under bright or fluorescent lighting
 |  |  |  |  |
| 1. Performance deteriorates under bright or fluorescent lighting
 |  |  |  |  |
| 1. Feel like there is not enough light when reading
 |  |  |  |  |
| 1. Feel like there is too much light when reading
 |  |  |  |  |
| 1. Prefer to read in dim lighting
 |  |  |  |  |
| 1. Shade the page with your hand or body
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Types of reading difficulty: | Yes/ Often | Yes/ Sometimes | No/ Never | Notes: |
| 1. Skip words or lines
 |  |  |  |  |
| 1. Repeat or reread lines
 |  |  |  |  |
| 1. Read with breaks
 |  |  |  |  |
| 1. Lose place
 |  |  |  |  |
| 1. Reading is slow or choppy (a “go and stop” rhythm)
 |  |  |  |  |
| 1. Skip small words
 |  |  |  |  |
| 1. Poor reading comprehension
 |  |  |  |  |
| 1. Reading becomes harder the longer you read
 |  |  |  |  |
| 1. Use your finger or marker to help keep your place
 |  |  |  |  |
| 1. Avoid reading
 |  |  |  |  |
| 1. Avoid reading for pleasure
 |  |  |  |  |
| 1. Rereads for meaning
 |  |  |  |  |
| 1. Reversals of letters (such as: b and d and p and q)
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| When reading or using a computer do you: | Yes/Often | Yes/ Sometimes | No/Never | Notes: |
| 1. Rub eyes
 |  |  |  |  |
| 1. Mover closer or further away
 |  |  |  |  |
| 1. Squint
 |  |  |  |  |
| 1. Open eyes wide
 |  |  |  |  |
| 1. Need to take breaks
 |  |  |  |  |
| 1. Change position to reduce glare
 |  |  |  |  |
| 1. Close or cover one eye
 |  |  |  |  |
| 1. Move head
 |  |  |  |  |
| 1. Read word by word
 |  |  |  |  |
| 1. Unable to speed/skim read
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you feel strained, fatigue, tired or have a headache when: | Yes/ Often | Yes/ Sometimes | Often | Notes: |
| 1. Reading
 |  |  |  |  |
| 1. Writing
 |  |  |  |  |
| 1. Doing paper and pencil tasks
 |  |  |  |  |
| 1. Working on the computer
 |  |  |  |  |
| 1. Whiteboards
 |  |  |  |  |
| 1. Watching TV, movies, or live stage productions
 |  |  |  |  |
| 1. Copying material from a book or whiteboard
 |  |  |  |  |
| 1. Doing maths assignments
 |  |  |  |  |
| 1. Doing long assignments
 |  |  |  |  |
| 1. Doing visually intensive activities like needlepoint, sewing, cross stitching, crossword puzzles, woodworking, soldering etc.
 |  |  |  |  |
| 1. Working under bright or fluorescent lights
 |  |  |  |  |
| 1. Looking at stripes, patterns, bright colours, and high contrast
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Handwriting:  | Yes/ Often | Yes/ Sometimes | No/ Never | Notes: |
| 1. Write up or down hill
 |  |  |  |  |
| 1. Unequal or no spacing between betters or words
 |  |  |  |  |
| 1. Unequal letter size
 |  |  |  |  |
| 1. Unable to write on the line
 |  |  |  |  |
| 1. Leave out words, letters, or punctuation marks
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Attention/Concentration:  | Yes/Often | Yes/ Sometimes | No/ Never | Notes: |
| 1. Problems concentrating with reading or writing
 |  |  |  |  |
| 1. Easily distracted when reading or writing
 |  |  |  |  |
| 1. Easily distracted when listening
 |  |  |  |  |
| 1. Easily distracted when taking tests
 |  |  |  |  |
| 1. Daydreams in class/lectures/work
 |  |  |  |  |
| 1. Problems staying on task
 |  |  |  |  |
| 1. Problems starting tasks
 |  |  |  |  |
| 1. Difficulty with scantron answer sheet
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Copying from a book or whiteboard: | Yes/Often | Yes/Sometimes | No/Never | Notes: |
| 1. Loose place
 |  |  |  |  |
| 1. Leave out words
 |  |  |  |  |
| 1. Slow
 |  |  |  |  |
| 1. Incomplete
 |  |  |  |  |
| 1. Errors
 |  |  |  |  |
| 1. Blink or squint
 |  |  |  |  |
| 1. Difficulty refocusing
 |  |  |  |  |
| 1. Difficulty copying things onto or off computer
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Essay Writing: | Yes/ Often | Yes/ Sometimes | No/ Never | Notes: |
| 1. Disorganised
 |  |  |  |  |
| 1. Problems with punctuation
 |  |  |  |  |
| 1. Problems proofreading
 |  |  |  |  |
| 1. Leave out letters or words
 |  |  |  |  |
| 1. Write without rereading
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mathematics:  | Yes/Often | Yes/Sometimes | No/Never | Notes: |
| 1. Misalign digits in number columns
 |  |  |  |  |
| 1. Difficulty seeing numbers in the correct column
 |  |  |  |  |
| 1. Sloppy or careless errors
 |  |  |  |  |
| 1. Use finger, graph paper, or other marker when working with columns of numbers
 |  |  |  |  |
| 1. Difficulty seeing signs, symbols, numbers, decimal points
 |  |  |  |  |
| 1. Reversals of numbers

(such as 6 and 9 and 5 and 2) |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Music:  | Yes/Often | Yes/Sometimes | No/Never | Notes: |
| 1. Problems sight reading the notes
 |  |  |  |  |
| 1. Prefer to memorize rather than read music
 |  |  |  |  |
| 1. Prefer to play by ear
 |  |  |  |  |
| 1. Use finger to track notes
 |  |  |  |  |
| 1. Lose your place
 |  |  |  |  |
| 1. Trouble reading the notes or notes and words together
 |  |  |  |  |
| 1. Difficulty interpreting the music notations
 |  |  |  |  |
| 1. Little progress despite regular practice
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Depth Perception: | Yes/ Often | Yes/Sometimes | No/Never | Notes: |
| 1. Difficulty getting on and off escalators
 |  |  |  |  |
| 1. Clumsy
 |  |  |  |  |
| 1. Bump into table or furniture edges
 |  |  |  |  |
| 1. Difficulty walking up and/or downstairs
 |  |  |  |  |
| 1. Difficulty judging distances
 |  |  |  |  |
| 1. Drop or knock things over
 |  |  |  |  |
| 1. Accidental prone
 |  |  |  |  |
| 1. Have bruises that you are not sure where they have come from
 |  |  |  |  |
| 1. When walking next to someone, do you drift into the person
 |  |  |  |  |
| 1. When walking, do you feel dizzy or light-headed
 |  |  |  |  |
| 1. Afraid of heights
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sports Performance: | Yes/Often | Yes/Sometimes | No/ Never | Notes: |
| 1. Problems tracking a flying ball like golf, cricket, tennis
 |  |  |  |  |
| 1. Trouble following the ball when watching sports on TV such as tennis, football, basketball
 |  |  |  |  |
| 1. When watching sports on TV, can you follow the ball but not see anything else
 |  |  |  |  |
| 1. Trouble catching or hitting a ball
 |  |  |  |  |
| 1. Difficulty playing pool
 |  |  |  |  |
| 1. Difficulty hitting the ball when playing tennis, badminton, cricket
 |  |  |  |  |
| 1. Trouble learning how to ride a bike
 |  |  |  |  |
| 1. Trouble jumping rope because you jump at the wrong time or jump into the rope
 |  |  |  |  |
| 1. Trouble playing ball games
 |  |  |  |  |
| 1. On playground equipment, do you find it difficult judging distances (for example, on the monkey bars – was it hard to go from one to the other)
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Driving: | Yes/ Often | Yes/Sometimes | No/ Never | Notes: |
| 1. Difficulty parallel parking
 |  |  |  |  |
| 1. Do you feel like you hit cars around you when parking
 |  |  |  |  |
| 1. When parking, do you hit the curb or leave too much space
 |  |  |  |  |
| 1. Difficulty judging when to turn in front of coming traffic
 |  |  |  |  |
| 1. Uncertain when making lane changes
 |  |  |  |  |
| 1. Extra cautious when making lange changes
 |  |  |  |  |
| 1. Are the passengers tense when you make lane changes
 |  |  |  |  |
| 1. Do passengers tell you that you drive too close to other cars
 |  |  |  |  |
| 1. Are you overly cautious, leaving extra room between you and the car ahead
 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fatigue while in a car: | Yes/Often | Yes/Sometimes | No/ Never | Notes: |
| 1. As a passenger, do you become drowsy
 |  |  |  |  |
| 1. When driving, do you become drowsy
 |  |  |  |  |
| 1. Bothered by glare on the chrome on cars
 |  |  |  |  |
| 1. Bothered by glare off the rear window of the car in front of you
 |  |  |  |  |
| 1. The glare makes it stressful to drive in snow or rain
 |  |  |  |  |
| 1. Avoid driving at night
 |  |  |  |  |
| 1. Bothered by headlights and streetlights at night
 |  |  |  |  |
| 1. Bothered by taillights on cars
 |  |  |  |  |
| 1. Bothered by red/green traffic lights
 |  |  |  |  |
| 1. Have night blindness
 |  |  |  |  |

Any other relevant information: (add another page if necessary)

**Please note:**

The information you supply on this form will be used solely for us to determine whether you may need screening for Irlen Syndrome and for us to make contact with you to discuss this further. At no stage are you under any obligation to have a full assessment. Nor will your details be used to promote our services in the future or be passed onto any third party. If, as a result of completing this form and discussing your symptoms, you decided to not go on further then the form will be destroyed.