



SELF -TEST FOR IRLEN SYNDROME

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

Name _____ Age _____ Grade _____
 Address _____ Phone _____
 Completed by _____ Date _____

CHARACTERISTICS

Please Circle Answer

Are you light sensitive?

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 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	?
Use fingers or other marker to block out part of the page	Yes	No	?
Shade the page with your hand or body	Yes	No	?

Types of reading difficulties:

Skip words or lines	Yes	No	?
Repeat or reread lines	Yes	No	?
Read for less than one hour	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 as you continue	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:

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	?

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

Reading	Yes	No	?
Listening	Yes	No	?
Doing paper and pencil tasks	Yes	No	?
Working on the computer	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 long assignments	Yes	No	?
Doing visually-intensive activities like needlepoint, sewing, cross stitching, crossword puzzles, woodworking, soldering, etc.	Yes	No	?
Working under bright or fluorescent lights	Yes	No	?
Looking at stripes, patterns, bright colors, and high contrast	Yes	No	?

Handwriting:

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	?

Attention/Concentration:

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:

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	?

Composition/Essay Writing:

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:

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	?

Music:

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:

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 down stairs	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 light headed	Yes	No	?
Difficulty getting on or off moving objects	Yes	No	?

Driving:

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	?

Sports Performance:

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 volley ball 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	?

Fatigue While In A Car:

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	?
Bothered by headlights and street lights at night	Yes	No	?
Avoid driving at night	Yes	No	?
Have night blindness	Yes	No	?
Bothered by red tail lights on cars	Yes	No	?
Bothered by red stop lights	Yes	No	?
Stressful to drive in the rain (glare)	Yes	No	?

If you answered yes to three or more of these questions in any one of the above sections, then you might be experiencing the effects of a perception problem called Irlen Syndrome/ Scotopic Sensitivity.

Reading Strategy Questionnaire (RSQ)

PART A

Name: _____

Date: _____

SAY: When reading for information and you get to the point where you want to stop reading:

	OFTEN	SOME-TIMES	NEVER	D.K.
1. Do you accidentally skip lines or sentences?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you lose your place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you misread words?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you unintentionally skip words?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you accidentally repeat or reread lines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you insert words from the line above or below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you avoid reading or reading aloud?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is your reading slow and choppy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you bothered by white or glossy pages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you look away or take breaks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you restless, active, fidgety, or easily distracted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you find that reading gets harder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you use your finger or marker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have a problem understanding what you read?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a problem remembering what you read?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Does it take effort to stay on the words you are reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reading Strategy Questionnaire (RSQ)

PART B

Name: _____

Date: _____

SAY: When reading for information and you get to the point where you want to stop reading:

	OFTEN	SOME-TIMES	NEVER	D.K.
1. Do your eyes bother you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do they get red or watery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do they hurt, ache, or burn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do they feel dry, sandy, scratchy, or itchy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you rub your eyes or around your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you feel tired, drowsy, or fatigued?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your head bother you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you get a headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you get dizzy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel nauseated or sick to your stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you open your eyes wide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you squint or frown?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you find yourself blinking frequently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you move closer to or further from the page?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Does it bother you to read under fluorescent lights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Is it harder to read in bright lights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>