irlen SCREENER

Name of Client: _____ **Age:** _____

Contact Name: _____

Phone number: _____

- Do you skip words or lines when reading? ..... Yes / No
- Do you reread lines? ..... Yes / No
- Do you lose your place? .....Yes / No
- Are you easily distracted when reading? .....Yes / No
- Do you often need to take breaks often? .....Yes / No
- Do you find it harder to read the longer you read?.....Yes / No
- Do you get headaches when you read? ..... Yes / No
- Do your eyes get red and watery? .....Yes / No
- Does reading make you tired? ..... Yes / No
- Do you blink or squint? ..... Yes / No
- Do you prefer to read in dim light? .....Yes / No
- Do you read close to the page? ..... Yes / No
- Do you use your finger or other markers? ..... Yes / No
- Do you get restless, active, or fidgety when reading?.....Yes / No

For further information about Irlen® Syndrome please visit www.irlen.com