

LEARNING NEEDS SCREENING

INTERVIEWER NAME: _____

INTERVIEW DATE: _____

STUDENT/CUSTOMER NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

GENDER: Male Female

HOW MANY YEARS OF SCHOOLING HAVE YOU HAD? _____

CHECK ALL EARNED: High School Diploma GED Technical/Vocational Certificate
 AA degree Other (specify): _____

WHAT KIND OF JOB WOULD YOU LIKE TO GET? _____

DO YOU HAVE EXPERIENCE IN THIS AREA? Yes No

WHAT MAKES IT HARD FOR YOU TO GET OR KEEP THIS KIND OF JOB? _____

WHAT WOULD HELP? _____

BEFORE PROCEEDING TO THE QUESTIONS, READ THIS STATEMENT ALOUD TO THE STUDENT/CUSTOMER:

The following questions are about your school and life experiences.

It's important to find out how it was for you (or your family members) when you were in school/training and if there is anything that would get in the way now as you pursue education or training. Your responses to these questions are confidential and will help identify resources and services you might need to be successful in education, training and securing employment.

Section A	
1. Did you have any problems learning in middle school or junior high school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do any family members have learning problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have difficulty working with numbers in columns?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have trouble judging distances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have problems working from a test booklet to an answer sheet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Count the number of "Yes's" for Section A</i>	
	___ X 1 = ___

Section B	
6. Do you have difficulty or experience problems mixing arithmetic signs (+/x)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Did you have any problems learning in elementary school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Count the number of "Yes's" for Section B</i>	
	___ X 2 = ___

Section C	
8. Do you have difficulty remembering how to spell simple words you know?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Do you have difficulty filling out forms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Did you (do you) experience difficulty memorizing numbers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Count the number of "Yes's" for Section C</i>	
	___ X 3 = ___

Section D	
11. Do you have trouble adding and subtracting small numbers in your head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you have difficulty or experience problems taking notes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Were you ever in a special program or given extra help in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Count the number of "Yes's" for Section D</i>	
	___ X 4 = ___
TOTAL YES'S MULTIPLIED BY FACTOR INDICATED FOR SECTIONS A, B, C, D	

14. Check to see if the student/customer has ever been diagnosed or told he/she has a learning disability.
If so,

By whom? _____

When? _____

Can you get the information or report? _____

NOTES: _____

LEARNING NEEDS SCREENING DIRECTIONS

1. Ask the student/customer each question in each section (A, B, C, D) and question #14.
2. Record the student/customer's responses, checking "Yes" or "No."
3. Count the number of "Yes" answers in each section.
4. Multiply the number of "Yes" responses in each section by the number shown in the section subtotal. For example, multiply the number of "Yes's" obtained in Section C by 3.
5. Record the number obtained for each section after the "=" sign in the section subtotal.
6. To obtain a Total, add the subtotals from sections A, B, C and D.
If the Total from sections A, B, C and D is 12 or more, refer for further assessment.

This Learning Needs Screening was developed by Nancie Payne, President and Senior Consultant, Payne & Associates, Inc., Olympia, Washington, under contract for the Washington State Division of Employment and Social Services Learning Disabilities Initiative (November 1994 to June 1997).

ADDITIONAL HEALTH SCREENING QUESTIONS TO ASK:

GLASSES/VISION:

- Do you need or wear glasses? Yes No
- Do you have trouble seeing? Yes No
- When was your last examination?
(within two years is acceptable) Yes No

HEARING:

- Do you need or wear a hearing aid? Yes No
- Do you have trouble hearing? Yes No
- Do you think you need a hearing exam? Yes No

MEDICAL/PHYSICAL:

Have you experienced any of the following (note age/when occurred with brief detail):

- multiple, chronic ear infections Yes No
- multiple, chronic sinus problems Yes No
- serious accidents resulting in head trauma Yes No
- prolonged, high fevers Yes No
- diabetes Yes No
- severe allergies Yes No
- frequent headaches Yes No
- concussion or head injury Yes No
- convulsions or seizures Yes No
- long-term substance abuse problems Yes No
- serious health problems Yes No

Are you taking any medications that would affect the way you function? Yes No

If yes, list medication: _____

How often (1x day, 2x day, etc.) _____

Is there a need for medical or follow-up services? Yes No

Referrals needed/made: _____

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