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.

See page 3 for directions and scoring

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

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

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

Section D	
11. Do you have trouble adding and subtracting small numbers in your head?	❑ Yes ❑ No
12. Do you have difficulty or experience problems taking notes?	❑ Yes ❑ No
13. Were you ever in a special program or given extra help in school?	❑ Yes ❑No
Count the number of "Yes's" for Section D	**___ X 4 = ___**

TOTAL YES'S MULTIPLIED BY FACTOR INDICATED FOR SECTIONS A, B, C, D	____

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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 <u>12 or more</u>, 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).

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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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