



# Irlen Manchester

[www.irlenmanchester.co.uk](http://www.irlenmanchester.co.uk)

## The Irlen® Self-Test

Name of person to be screened:

Client DOB:

Name of Parent/Guardian if applicable:

Contact Telephone number:

Contact Email address:

<b>ENVIRONMENT/DEPTH PERCEPTION</b>	<b>YES</b>	<b>NO</b>
Hold onto the railing/wall going up and down the stairs?		
Trip up at the top or bottom of the stairs?		
Sometimes think there is another step but there isn't?		
Bump into the edges of furniture or doorways by accident?		
When walking with people you tend to walk into them?		
When walking you tend to veer off to one side?		
Found learning to ride a bike difficult because of poor balance?		
Still have difficulty going in a straight line on a bike?		
Tend to hit the kerb if riding a bike too close to the kerb?		
Hesitate when using escalators?		
Feel dizzy on heights or ladders?		
Have difficulty catching a ball?		
Clumsy or accident prone?		
Feel dizzy/light headed when walking around normally?		
Having difficulty skipping or jumping?		
Have difficulty with merry-go-round or rides at fairs?		
Drop things easily or knock things over easily?		
Tend to put things too close to the edge of a table or surface?		

Tend to be extra cautious when parking or overtaking cars?		
Find it difficult to judge the speed of other cars?		
Find it difficult to drive and take in things around you?		

<b>READING</b>	<b>YES</b>	<b>NO</b>
Enjoy reading?		
Use a marker/finger to keep your place?		
Easily lose your place?		
Skip lines?		
Skip words?		
Re-read lines by mistake?		
Re-read lines for meaning?		
Read for only a short time?		
Find reading gets worse with time?		
Find that words look different or change after a while?		
Shade the page to reduce glare?		
Move closer to the page?		
Move further from the page?		
Become restless?		
Become easily distracted?		

<b>STRAIN AND FATIGUE: with reading, computer or other activities</b>	<b>YES</b>	<b>NO</b>
Need to take frequent breaks?		
Rub eyes?		
Frown or squint?		
Blink frequently?		
Open eyes wide?		
Feel drowsy?		
Feel dizzy?		
Feel nauseous?		
Get a headache?		
Eyes feel tired or strained?		
Eyes hurt/ache/burn (circle as appropriate)		
Eyes go red/watery? (circle as appropriate)		
Eyes feel dry/itchy? (circle as appropriate)		

<b>LIGHT SENSITIVITY</b>	<b>YES</b>	<b>NO</b>
Bothered by: bright sunshine?		
Bothered by: bright lights?		
Squint in bright sunlight?		
Prefer to stay in the shade?		
Prefer to wear sunglasses/hat? (circle as appropriate)		
Eyes need to adjust going from dark to light places?		
Bothered by: glare in the environment?		
Bothered by: fluorescent lighting?		
Bothered by: glare on the white page when reading?		
Bothered by: glare/brightness of computer screens?		
Bothered by: bright colours?		
Bothered by: stripes/polka dots/patterns?		
Bothered by: glare when driving		

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

**The information you supply on this form will be used solely for us to determine whether you may need testing 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 decide to go no further then the form will be destroyed**