Literacy Solutions
Sara Graham
Dyslexia Consultant

The Irlen® Self Test

Name: **City or Town:**

Contact Telephone Number: **E-Mail Address:**

ENVIRONMENT/DEPTH PERCEPTION	YES	NO
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 tend to keep running into them?		
When walking with people veer off to one side?		
Have trouble learning to ride a bike because if balance?		
Still have difficulty going in a straight line on a bike?		
Tend to hit the kerb if riding close to the kerb?		
Hesitate to have difficulty with 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 rope?		
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?		
Find it difficult to judge the speed of other cars?		
Find it difficult to drive and take in things around you?		

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READING	YES	NO
Enjoy reading?		
Use a marker to keep place?		
Lose your place?		
Skip lines?		
Skip words?		
Reread lines by mistake?		
Reread 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?		
More closer to the page?		
Move further from the page?		
Becomes restless?		
Become easily distracted?		

STRAIN AND FATIGUE: with reading, computer or other activities	YES	NO
Need 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 red/watery? (circle as appropriate)		
Eyes dry/itchy? (circle as appropriate)		

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LIGHT SENSITIVITY	YES	NO
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 screen?		
Bothered by: bright colours?		
Bothered by: stripes/polka dots/patterns?		
Bothered by: glare when driving		

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

Please Note:

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 competing this form and discussing your symptoms, you decided to go no further then the form will be destroyed