

## TEACHER INSTRUCTIONS

- In each section, count the number of “yes” answers.
- Multiply the number of “yes” responses in each section by the number shown in that section. For example, multiply the number of Section 2 “yes” statements by 2 and Section 3 “yes” statements by 3.
- Record the number on the line provided.
- Add up the numbers and enter at the very bottom of the page.
- **If the total is 12 or more, that should be a red flag that the student has some special learning needs.**

**If you have any further questions, please contact Donna Potter at KYAE (502-573-5114, ext. 121).**

**Please keep scrolling down in order to access the Learning Needs Screening.**

# LEARNING NEEDS SCREENING

Interviewer Name: \_\_\_\_\_

Interview Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ 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 CLIENT:

The following questions are about your school and life experiences.

We're trying to find out how it was for you (or your family members) when you were in school or how some of these issues might affect your life now. Your responses to these questions will help identify resources and services you might need to be successful securing employment.

See final page for directions and scoring.

**The Learning Needs Screening is not a diagnostic tool and should not be used to determine the existence of a disability.**

<b>Section A</b>	
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 having 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
<b>Count the number of "Yes's" for Section A</b>	<b>X 1 =</b>

<b>Section B</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
<b>Count the number of "Yes's" for Section B</b>	<b>X 2 =</b>

<b>Section C</b>	
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 (or do you) experience difficulty memorizing numbers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Count the number of "Yes's" for Section C</b>	<b>X 3 =</b>

<b>Section D</b>	
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
<b>Count the number of "Yes's" for Section D</b>	<b>X 4 =</b>

**Total "Yes's" multiplied by factor indicated for Sections A, B, C, D**

See final page for directions and scoring.

**The Learning Needs Screening is not a diagnostic tool and should not be used to determine the existence of a disability.**

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

By whom? \_\_\_\_\_

When? \_\_\_\_\_

NOTES: \_\_\_\_\_

---

---

---

## LEARNING NEEDS SCREENING DIRECTIONS

1. Ask the client each question in each section (A, B, C, D) and question #14.
2. Record the client'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.**

NOTE: It is recommended interviewers ask an additional set of medical/health-based questions to gather more complete background information.

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

---

**The Learning Needs Screening is not a diagnostic tool  
and should not be used to determine the existence of a disability**

## ADDITIONAL QUESTIONS WHICH MAY BE ASKED:

### GLASSES:

Does the client need or wear glasses? Yes  No

Last examination was within two years? Yes  No

### HEARING:

Does the client need or wear a hearing aid? Yes  No

### MEDICAL/PHYSICAL:

Has the client experienced any of the following?:

- 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

Is the client taking any medications that would affect the way he/she is functioning? Yes  No

If yes, what is the client taking? \_\_\_\_\_

How often? \_\_\_\_\_

Does the client need medical or follow-up services? Yes  No

Referrals needed/made: \_\_\_\_\_

---

---

---

# LEARNING NEEDS SCREENING

## CLIENT COPY

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 any experience in this area?

What makes it hard for you to get or keep this kind of job?

What would help?

The following questions are about your school and life experiences.

We're trying to find out how it was for you (or your family members) when you were in school or how some of these issues might affect your life now. Your responses to these questions will help identify resources and services you might need to be successful securing employment.

1. Did you have any problems learning in middle school or junior high school?
2. Do any family members have learning problems?
3. Do you have difficulty working with numbers in columns?
4. Do you have trouble judging distances?
5. Do you have problems working from a test booklet to an answer sheet?
6. Do you have difficulty or experience problems mixing arithmetic signs (+/x)?
7. Did you have any problems learning in elementary school?
8. Do you have any difficulty remembering how to spell simple words you know?
9. Do you have difficulty filling out forms?