LEARNING NEEDS SCREENING TOOL 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.

Interviewers must ask the additional set of medical/health-based questions to gather more complete background information.

Refer to the Learning Needs Screening Tool Question and Descriptions and Follow-up Explanations to clarify terms and meanings to obtain an accurate response from the participant.

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.

LEARNING NEEDS SCREENING

Interviewer Name: _____ Interview Date: _____

Client Name: _____ Date of Birth:_____

Case ID #: _____ 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?

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 "Yeses" 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 "Yeses" 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 (or do you) experience difficulty memorizing numbers?	__ Yes __ No
Count the number of "Yeses" 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 "Yeses" for Section D X 4 =	
Total "Yeses" multiplied by factor indicated for A, B, C, D	
See next page for directions and scoring.	
14. Check to see if the client has ever been diagnosed or told he/she has a learning disability. If so, by whom and when?	

ADDITIONAL QUESTIONS TO ASK:

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:

_____

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.