



The Reading Center

DYSLEXIA INSTITUTE OF MINNESOTA

"Toward Literacy for All"

847 5th Street NW

Rochester, MN 55901

507-288-5271

fax 507-288-6424

# Registration for Educational Services For Adults

FOR OFFICE USE ONLY	Date Received:	Charges: \$	Scholarship: \$	Client #:
Today's Date:		What kind of services are you requesting from the Reading Center? <input type="checkbox"/> Full Evaluation <input type="checkbox"/> Abbreviated Evaluation		
<b>CLIENT'S NAME:</b>				
BIRTHDATE:	AGE:	Sex:	Highest Level of Education Completed:	
Ethnic Origin:	Have you received any other services from the Reading Center? <input type="checkbox"/> Yes <input type="checkbox"/> No			
This form is being filled out by:				
Relationship to applicant:				
Address:				
City/State/Zip:			County:	
E-Mail:				
Phones H/W/Cell:				
Employer or College:				
If you would like to pay by credit card, please indicate amount paid: _____				
Visa/Master Card Account # _____			Exp. Date _____	
Name on Card: _____			Cardholder Signature: _____	

**Please return this completed form with your \$200 deposit for services to the Reading Center. Upon receipt, you will be contacted to schedule an appointment for the evaluation. See below for deposit refund conditions.**

Signature of person financially responsible for services \_\_\_\_\_ DATE: \_\_\_\_\_

The Reading Center is committed to providing equal access to its services for individuals from diverse populations. **Deposit refund conditions:** • Cancel prior to two weeks before testing date, \$25 is not refunded, of the \$200 fee. • Cancel within two weeks before testing date, \$50 is not refunded, of the \$200 fee. • Same day no-show for testing, \$100 is not refunded, of the \$200 fee.

**Please mark the type of service that you are requesting from the Reading Center.**

I agree upon fees of:

- \$825 Full Educational Evaluation (2 days for evaluation/conference)
  - \$925 Full Educational Evaluation (1 day for testing/conference)
  - \$355 Abbreviated Educational Evaluation (no written report)
  - \$230 Reading Skills Assessment
- (Requires a recent medical/educational report approved by a Reading Center tester.)

Important note: Clients selecting the Abbreviated Educational Evaluation do not receive any written documents beyond the profile of test scores. If the client expects to provide the results of the testing to their school, or for any other reason desires a written report of test findings, then they should choose the Full Educational Evaluation. If a client has elected to have the Abbreviated Educational Evaluation and after the testing is completed, determines that they wish to have the Full Educational Evaluation so that they might have a written report, this must be requested NO LATER than 2 weeks after the conference. When this is requested the client will pay the balance of the fee difference (additional \$470) and we will schedule the additional testing required to support recommendations for findings and accommodations.

---

How did you learn of the Reading Center? *(Please give name so we can thank them!)*

- Teacher    Friend    Doctor    Newspaper    Other \_\_\_\_\_

Do you have any previously administered evaluation summaries, IEPs, and/or Section 504 Plans available for review?    Yes    No

♦ *If yes, please provide the information to the Reading Center in advance of your testing date.*

Are you taking medication that may affect your performance in a testing situation?    Yes    No *(If yes, please provide details. Make sure that any medications normally taken are also administered on the day of the evaluation.)*

---

---

Has your hearing or vision been checked recently?    Yes    No

♦ *Please provide details if the results were notable.*

---

---

How do you see the Reading Center helping you?

---

---

What concerns brought you to the Reading Center?

---

---



# Information Form Adult Client Questionnaire

"Toward Literacy for All"  
847 5th Street NW Rochester, MN 55901  
507-288-5271

Test Date: \_\_\_\_\_ Time: \_\_\_\_\_ Evaluator: \_\_\_\_\_  
Date: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Client's Name: \_\_\_\_\_ Home phone number: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Cell phone number: \_\_\_\_\_  
Address: \_\_\_\_\_ Business phone number: \_\_\_\_\_  
City: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ e-mail: \_\_\_\_\_

Name of School Attended: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Have you ever been held back a grade? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever skipped a grade? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain reason for referral. Describe in your own words your difficulty, as you understand it. Please include difficulties reported by others and your own observations:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your expectations in regard to this evaluation?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have had other testing and/or tutoring, please describe:

---

---

---

---

---

---

If you have had concerns about your school achievement, please describe them:

---

---

---

---

What do you consider to be your strengths? Weaknesses?

---

---

---

---

---

---

---

Describe your study habits, if applicable, average time spent on homework, and study environment (quiet, loud, in bedroom, in family room):

---

---

---

---

---

---

---

---

---

---

It is generally accepted that learning difficulties run in families. Do you know of other relatives in the immediate or extended family who struggled in school or had a diagnosis such as LD or ADHD?

No \_\_\_\_\_ Yes \_\_\_\_\_ (Explain below) Adopted \_\_\_\_\_

---

---

---

Date of last vision check with an eye doctor? \_\_\_\_\_

Results: \_\_\_\_\_

Date of last hearing check? \_\_\_\_\_ Ear infections? \_\_\_\_\_ yes \_\_\_\_\_ no

Results: \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

---

**History of illness (please check all that apply)**

- Complicated Pregnancy
  - Illness at Birth
  - Serious Accident
  - Serious Illness
  - Vision Impairment
  - Allergies
  - Received Speech Therapy
  - Physical Disability
  - Continuing Health Problems
  - Developmental Delays
  - Motor Delays
  - Diagnosed EBD
  - Diagnosed ADHD
  - Diagnosed Asperger's
  - Diagnosed Autism
  - Diagnosed Anxiety
  - Diagnosed ODD
  - Diagnosed OCD
  - Diagnosed Depression
  - Additional Medical History
  - Procedures with General Anesthetic
- Years of Age     0-1    \_\_\_\_\_  
                           1-2    \_\_\_\_\_  
                           2-3    \_\_\_\_\_  
                           3-5    \_\_\_\_\_  
                           5-10    \_\_\_\_\_  
                           10+    \_\_\_\_\_

List of Medications \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

Please respond to the items below. Please feel free to include additional comments.

**Early Childhood Development:**

	Yes	No	Yes	No
speech hard to understand			enjoyed looking at books	
delayed speech			had difficulty following one- or two-step directions	
enjoyed being read to			stuttered/continues to stutter	
played rhyming games				

**Preschool and Kindergarten:**

	Yes	No	Yes	No
did your attitude change when you entered school			"pretended" to read before learning to read	
was easily frustrated or discouraged while doing paper and pencil activities			could not seem to remember a list/directions	
had a short attention span			had confusion about handedness	
mispronounced words			had professional speech therapy	

**Elementary Grades:**

	Yes	No	Yes	No
did not speak in complete sentences at the start of first grade			did not hold pencil appropriately	
had trouble pronouncing correct sounds of letters			held pencil in different hand from one you ate with	
mispronounced words			had trouble writing on the line	
hated to read			had poor handwriting	
read but did not comprehend			wrote awkwardly	
omitted words when reading or writing			had difficulty copying accurately from book or board to paper	
continued to experience reversals			poor speller	
teacher thought you were not trying			blinked, rubbed, or covered eyes frequently	
teacher thought you did not pay attention			had difficulty rhyming words	

**Middle School and High School:**

	Yes	No	Yes	No
did not like change			could not tell time with an analog clock	
liked to work with your hands			underlined from right to left	
had headaches or nausea after reading			had difficulty finding the "right" word when speaking	
highly verbal; have an excellent verbal vocabulary			written vocabulary was simpler than speaking vocabulary	
"forget" what you are supposed to do			had difficulty rhyming words	