



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		
CLIENT'S NAME:				
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. • VISA refunds, deduct 3% processing 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 Education 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.)
- add \$70 for online testing (technology and tech troubleshooting fee)

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?



The Reading Center
DYSLEXIA INSTITUTE OF MINNESOTA
"Toward Literacy for All"
847 5th Street NW Rochester, MN 55901
507-288-5271

Information Form Adult Client Questionnaire

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)

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

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		