PATHWAYS
Literacy Center

Improving Literacy, Changing Lives

Prescreening Information

Parent Name:_____

Full Address:_____

Email:_____ Phone #:_____

Screening for (child's name):_____ Age:_____ Grade:_____

Referred by (first and last name): _____

Questionnaire

Please mark in the box labeled either "yes" or "no" to the questions below regarding your child.

	Yes	No	
1.	❑	❑	Chronic ear infections? Or Tubes in ears?
2.	❑	❑	Born prematurely If yes, number of weeks:_____
3.	❑	❑	Has difficulty remembering math facts
4.	❑	❑	Has/had eye training
5.	❑	❑	Receives Special Ed Services and/or is on an IEP
6.	❑	❑	Has received speech/language therapy
7.	❑	❑	Reverses letters when writing
8.	❑	❑	Substitutes words when reading
9.	❑	❑	Memorizes spelling words for the week but can't spell them two weeks later
10.	❑	❑	Avoids reading aloud in classroom
11.	❑	❑	Close relative(s) has/have dyslexia