PLEASE FILL OUT THIS QUESTIONNAIRE REGARDING THE INDIVIDUAL WITH AUTISM AND MAIL TO:
IRLEN INSTITUTE, 5380 VILLAGE ROAD, LONG BEACH, CA 90808.

NAME_____ AGE_____
ADDRESS_____STATE_____ZIP_____

SECTION A

Please explain any "yes" response and use reverse side for additional space. Age:_____State:____

1. Any problems with the pregnancy? Yes/No Explain:

2. Any difficulty with the birth? Yes/No Explain:

3. Any serious illness or disease? Yes/No Explain:

4. Environmental allergies? Yes/No Explain:

5. Any food sensitivities? Yes/No Explain:

   Foods that cause problems talking, thinking or sitting still:

   Foods that cause fatigue or lethargy:

   Foods that cause stomachaches:

   Foods that cause headaches:

   Other problems:

6. Any sensitivity to certain smells such as hair sprays, perfumes, or detergents? Yes/No Explain:

7. Any problems if a meal is skipped?
   Headaches_____Dizzy_____Moody_____Stomachaches_____
   Active_____Tired ____Shaky _____Irritable_____Other_____

8. Any problems going to sleep or staying asleep? Yes/No Explain:

9. Sensitivity to certain clothing or fabrics? Yes/No Which ones.

10. Difficulty or resists wearing tight clothing? Yes/No Explain:

11. Reacts negatively or is sensitive to certain sounds? Yes/No Explain:

12. Headaches or migraines? Yes/No Explain what triggers these attacks.

13. Circle the stimuli that are bothersome, painful or aversive: Smells Sounds Touch Lights Patterns Textures Other (list)

14. Circle the stimuli which have a "mesmerizing" effect: Lights Colors Patterns Sparkles Textures Spinning Moving Other (list)

15. Is there a family history of autism? Yes/No Relationship

16. Is anyone in the family light sensitive? Is anyone bothered by sunlight, glare, or does anyone prefer to wear sunglasses outside? Yes/No Relationship

17. Does anyone in the family avoid reading or avoid reading for pleasure? Yes/No Relationship

18. Does anyone take breaks while reading or only read magazines or newspapers rather than preferring to read for an hour or longer at a time? Yes/No Relationship

19. Does anyone in the family have learning problems or dyslexia? Yes/No Relationship

20. Does anyone in the family have a history of headaches or migraines related to lights or reading? Yes/No Relationship

SECTION B

Please explain any "yes" responses and use reverse side for more space.

1. Were there ever problems coloring and staying within the lines? Yes/No/?

2. Were there ever problems being able to cut on a straight line? Yes/No/?

3. Problems walking on straight lines on the floor? Yes/No/?

4. Avoidance or trouble using revolving doors? Yes/No/?

5. Likes to watch doors open and close? Yes/No/?

6. Difficulty or hesitation getting on or off moving things like an escalator? Yes/No/?

7. Difficulty picking things up or putting them down? Yes/No/?

8. Hesitation or fear going up or down stairs? Yes/No/?

9. Difficulty catching balls? Yes/No/?

10. Acts calmer or prefers to be in dim lights? Yes/No/?

11. Squints or closes one eye in bright light? Yes/No/?

12. Changes the brightness control on the TV? **Yes/No/?**

13. Plays with the color control setting on the TV? Yes/No/?

14. Avoids automatic doors? **Yes/No/?**

15. Squirms or becomes overactive under fluorescent lights? Yes/No/?

16. Does behavior change under fluorescent lights? **Yes/No/?**

17. Appears to stare at certain patterns or stripes? Yes/No/?

18. Bothered by or dislikes certain colours? **Yes/No/?**

SECTION C

	NEVER	SOMETIMES	OFTEN
1. Preference for the lights dimmed or turned off?	0	1	2
2. Squints when asked to look at something?	**0**	**1**	**2**
3. Periodically blinks in a series or bout?	0	1	2
4. Looks at things in a series of short glances?	**0**	**1**	**2**
5. Identifies or repeats the name of something being held for viewing but does not look at it?	0	1	2
6. Shields one eye while sitting or walking?	**0**	**1**	**2**
7. Rubs or pushes on the eyes?	0	1	2
8. Views a scene by turning the head and appears to stare?	**0**	**1**	**2**
9. Looks down or up at the ceiling while walking?	0	1	2
10. Looks through fingers?	**0**	**1**	**2**
11. Looks away from visual targets?	0	1	2
12. Appears startled when approached?	**0**	**1**	**2**
13. Startles when there is no apparent object?	0	1	2
14. Widens eyes or stares when looking at things?	**0**	**1**	**2**
15. Squirms or becomes overactive in bright lights?	0	1	2
16. Sits under shady trees when outside?	**0**	**1**	**2**
17. Picks strange colors for the computer screen or turns the brightness down?	0	1	2

SECTION D

Please explain any "yes" responses and use the reverse side for space.

1. Do certain types of lights bother you? Yes/No Explain:
2. Do lights sometimes have halos, starbursts, or colours around them? Yes/No Explain:

3. Do you ever see little spots of brightness or colour ? Yes/No Explain:

4. Is it difficult to look at some faces? Yes/No Explain:

5. Do you see colours when you look at things? Yes/No Explain:

6. Do some papers look shiny, too "white," or too bright? Yes/No Explain:

7. Does it hurt to look at a white page? Yes/No Explain:

8. Do things seem to be coming at you? Yes/No Explain:

9. Is it hard to look at some stripes or patterns? Yes/No Explain:

10. Do you dislike or are bothered by certain colours? Yes/No Explain:

11. Do you find it easier to squint or look out of the side of your vision? Yes/No Explain:

12. What it is like to look at people? Yes/No Explain:

13. What is it like to look at things? Yes/No Explain:

14. Do things around you move or change, such as: walls, stairs, wallpaper, furniture, carpet patterns? Yes/No Explain:

15. Do things seem to appear and disappear? Yes/No Explain:

16. Do things seem to fly apart? Yes/No Explain:

17. Do you find it harder to understand what you see or hear in rooms that have fluorescent or bright lights? Yes/No Explain:

18. Do you find traveling in a car at times upsetting? Yes/No Explain:

19. Do you find it difficult to play catch with a ball? Yes/No Explain:

20. Do you find that you have negative reactions to stairs, escalators, or driving? Yes/No Explain:

21. Do your eyes get tired when you look at pages with print on them or read? Yes/No Explain:

22. Does it get hard to hear? Yes/No Explain:

23. When things become hard to look at, does it make it hard to hear? Yes/No Explain:

SECTION E

NEVER SOMETIMES OFTEN ?

1. When doing seat work, does your child lose his/her place or skip lines?	0	1	2	?
2. Does your child rub surfaces?	0	1	2	?
3. When writing, does your child use an atypical position or workpaper placement?	0	1	2	?
4. When reading or writing, does your child move back and forth?	0	1	2	?
5. Does your child choose the same coloured crayon, marker, or pen?	0	1	2	?
6. Does your child prefer coloured paper?	0	1	2	?
7. Does your child work quickly?	0	1	2	?
8. Is your child better at reading larger print?	0	1	2	?
9. Does your child read better from the blackboard or a vertical surface?	0	1	2	?
10. While reading, does your child say letters first instead of words?	0	1	2	?
11. Does your child misread words?	0	1	2	?
12. Does your child miss spaces between words, combining letters or words?	0	1	2	?
13. Does your child misunderstand or cannot follow directions?	0	1	2	?
14. When reading, does your child repeat words or lines?	0	1	2	?
15. When reading aloud, does your child skip words or lines?	0	1	2	?