OVRS Questionnaire, NoteWorthy Learning

Date: _____

Client Name:_____ DOB:_____

E-Mail_____ Contact Phone #'s _____ _____

VR Counselor_____

E-Mail_____ Contact Phone _____ _____

Gender: M F **Years of School Completed** K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Have you earned any Diplomas or Degrees? Circle: HS Grad AA BA +

Have you earned any special certificates or licenses? (If so, please state)_____

What is your primary Disabling Condition _____ Secondary? _____

Date of Occurrence:_____ Date of Occurrence:_____

Circle your Primary Disabling Condition? Circle: Physical, Medical, Mental

Do you have other Disabling Conditions? Circle all that apply: Physical, Medical, Mental

Check limitations & Circle changes you have had with any of these activities or functions:

[_] Walking:	Getting better	Getting worse	
[_] Balance:	Getting better	Getting worse	
[_] Eyesight:	Getting better	Getting worse	
[_] Hearing:	Getting better	Getting worse	
[_] Stooping		[_] Migraines	[_] Hearing Aide
[_] Bending		[_] Cataracts	[_] Breathing
[_] Upper Body		[_] Glaucoma	[_] Breathing Aide
[_] Range of Motion		[_] Lazy Eye	[_] Medication
[_] Grasping		[_] Strabismus	[_] Special Diet
[_] Limit Duration of Sitting		[_] Wall Eye	[_] Cane
[_] Limit Duration of Standing		[_] Short Reading Sessions	[_] Other?_____
[_] Ramp		[_] Frequent Work Breaks	[_] Other?_____
[_] Wheelchair		[_] Glasses	
[_] Walker		[_] Prisms	

Date of last visual exam:_____

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- SOI Profile of Interpretation Manual for Clinical Training, Pages 7, 23, 25, Copyright© 1997, Mary Meeker.
- A Personal Career Evaluation, Copyright© Mary Meeker 1989, 1991.
- A Beginner's Reader About J.P. Guilford's Structure of Intellect, Copyright© Mary Meeker 1963, 2001.
- Education Analysis-SOI Learning Abilities Test, Form CR, Pages 4, 6, 7, Copyright© 2007 by Robert Meeker.
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Client_____

Abilities Questionnaire:

How well do you perform the following tasks? You can circle **"Really Well", "OK", or "Not Well."**

Coordinate small objects, visual objects, and sustain reading related activities that require visual focusing?

Really Well **OK** **Not Well**

Understand, Organize, and Classify Materials, or Ideas?

Really Well **OK** **Not Well**

Good eye-hand coordination when things need to be done fast?

Really Well **OK** **Not Well**

Keep materials organized?

Really Well **OK** **Not Well**

Concentrate on, recall, process numbers, visual details or written information? (Hold information in your mind and recall it in a different sequence?)

Really Well **OK** **Not Well**

Concentrate on, recall and change the sequence of information (numbers) you see?

Really Well **OK** **Not Well**

Work and communicate with verbal ideas (vocabulary)?

Really Well **OK** **Not Well**

Understand and communicate with abstract ideas and thinking?

Really Well **OK** **Not Well**

Follow Directions the first time they are given?

Really Well **OK** **Not Well**

Recall details in written material.

Really Well **OK** **Not Well**

Remember and accurately apply information to the problem at hand. Take initiative?

Really Well **OK** **Not Well**

Read, and scan data, items or words?

Really Well **OK** **Not Well**

Use arithmetic facts from memory and perform tasks that require concentration.

Really Well **OK** **Not Well**

Solve problems that require concentration, judgment and planning in data-dependent tasks?

Really Well **OK** **Not Well**

Organize space and materials?

Really Well **OK** **Not Well**

Remember and follow spoken instructions, (mental arithmetic).

Really Well **OK** **Not Well**

Remember and follow auditory instructions accurately?

Really Well **OK** **Not Well**

Conceptualize and organize numerical data?

Really Well **OK** **Not Well**

Understand spatial systems?

Really Well **OK** **Not Well**

Understand objects and shapes in space from any perspective?

Really Well **OK** **Not Well**

Discover and search out information when information on the job is abstract and ambiguous.

Really Well **OK** **Not Well**

Use math concepts?

Really Well **OK** **Not Well**

Make accurate decisions, using logic, good-judgment and planning to solve problems?

Really Well **OK** **Not Well**

Creatively express spatial ideas.

Really Well **OK** **Not Well**

Creatively apply symbolic and numerical concepts?

Really Well **OK** **Not Well**

Apply numerical concepts creatively.

Really Well **OK** **Not Well**

Visually discriminate, use good eye hand coordination to work with and make decisions about detailed figural information.

Really Well **OK** **Not Well**

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SECTION 1: READING STRATEGY QUESTIONAIRE (RSQ)

SECTION 1 RSQ

SAY: Think about what reading for information is like when you get to the point where you want to stop reading. You can answer "Often," "Sometimes," "Never," or Don't Know "D.K."

READING DIFFICULTIES

	Often	Some-times	Never	D.K.
1. Do you accidentally skip lines or sentences?	☐	☐	☐	☐
2. Do you lose your place?	☐	☐	☐	☐
3. Do you misread words?	☐	☐	☐	☐
4. Do you unintentionally skip words or punctuation marks?	☐	☐	☐	☐
5. Do you read the same line over again?	☐	☐	☐	☐
6. Do you insert words from lines above or below?	☐	☐	☐	☐
7. Do you avoid reading or reading aloud?	☐	☐	☐	☐
8. Is your reading slow or choppy?	☐	☐	☐	☐
9. Are you bothered by white or shiny pages?	☐	☐	☐	☐
10. Do you look away, rest, or take breaks?	☐	☐	☐	☐
11. Are you restless, active, fidgety, or easily distracted?	☐	☐	☐	☐
12. Do you find that reading gets harder the longer you read?	☐	☐	☐	☐
13. Do you use your finger or marker?	☐	☐	☐	☐
14. Do you have a problem understanding what you read?	☐	☐	☐	☐
15. Do you have a problem remembering what you read?	☐	☐	☐	☐
16. Does it take effort to stay on the words you are reading?	☐	☐	☐	☐
17. What else happens when reading?				

_____

_____

Often Sometimes
TOTAL = (_____ X 1) + (_____ X ½) =

READING DISCOMFORT

	Often	Some-times	Never	D.K.
1. Do your eyes bother you?	☐	☐	☐	☐
2. Do they get red or watery?	☐	☐	☐	☐
3. Do they hurt, ache, or burn?	☐	☐	☐	☐
4. Do they feel dry, sandy, scratchy, or itchy?	☐	☐	☐	☐
5. Do you rub your eyes or around your eyes?	☐	☐	☐	☐
6. Do you feel tired, drowsy or fatigued?	☐	☐	☐	☐
7. Does your head bother you?	☐	☐	☐	☐
8. Do you get a headache?	☐	☐	☐	☐
9. Do you get dizzy?	☐	☐	☐	☐
10. Do you feel nauseated or sick to your stomach?	☐	☐	☐	☐
11. Do you open your eyes wide?	☐	☐	☐	☐
12. Do you squint or frown?	☐	☐	☐	☐
13. Do you find yourself blinking frequently?	☐	☐	☐	☐
14. Do you move closer to or further from the page?	☐	☐	☐	☐
15. Does it bother you to read under fluorescent lights?	☐	☐	☐	☐
16. Is it harder to read in bright lighting?	☐	☐	☐	☐
17. What else bothers you?				

_____

_____

Often Sometimes
TOTAL = (_____ X 1) + (_____ X ½) =

SCORE: Total the number of checks in the "OFTEN" column and multiply by ONE. Total the checks in the "SOMETIMES" column and multiply by HALF (1/2). Add one point for any additional response to Question #17. Add together the total for each section. Circle the appropriate numbers on the Profile Sheet.

READING HISTORY

DIRECTIONS: When answering these questions, think about what reading is like when you are reading for information and you get to the point you want to stop reading:

(a) How do you, your head, and your eyes feel? (b) How does the page look when you want to stop reading? What is your first symptom, (a) or (b)? When do you first notice that this problem starts-after you read a word, a paragraph, a few pages, five to ten minutes, chapter, 30 minutes? (Circle answer)

If you read a lot, do you ever get a headache or feel dizzy, nauseous, or very sleepy? (Circle answers)