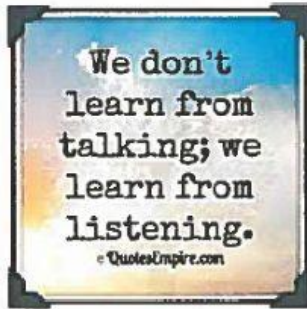




I'm Listening

Your name: _____

Birthday: _____

Age: _____

Town you live in: _____

Grade school you graduated from: _____

How long is your bus ride? _____

Do you have brothers or sisters? If so, how many?

Favourite way to spend your time: _____

Your favourite school subject: _____

Do you have a part-time job: _____

Is yes, where and what do you do? _____

What do you want to do when you graduate from high school?

What is your favourite type of music? _____



Let me help you ...

- | | | |
|---|-----|----|
| 1. Do you need help with reading? | YES | NO |
| 2. Do you need help with writing? | YES | NO |
| 3. Do you do better if tests are read to you? | YES | NO |
| 4. Do you need glasses or have trouble
with your eyes? | YES | NO |
| 5. Do you have hearing difficulties? | YES | NO |
| 6. Do you have trouble copying notes? | YES | NO |
| 7. What type of learner are you? (Circle whatever applies). | | |
| VISUAL (need to watch it) HANDS-ON (need to do it) | | |
| AUDITORY (need to hear it) | | |
| 8. Do you have any allergies? | YES | NO |
| If yes, what are they? _____ | | |