BIT BEHAVIORAL CHECK LIST

NAME: _____ **DATE:** _____

Please check anything which **might** apply, and put **two checks** against anything which is especially important.

- ☐ Accident prone
- ☐ Allergies (feel tired or hyper-active after eating)
- ☐ Clumsy
- ☐ Constipated
- ☐ Daydreams excessively
- ☐ Difficulty budgeting time
- ☐ Difficulty concentrating
- ☐ Difficulty focusing eyes
- ☐ Difficulty following directions
- ☐ Difficulty giving directions
- ☐ Difficulty telling time
- ☐ Dizziness / vertigo / balance problems
- ☐ Eye strain / rubs eyes a lot
- ☐ Fear of speaking in front of a group
- ☐ Has trouble remembering directions
- ☐ Has trouble remembering months of the year
- ☐ Has trouble remembering names
- ☐ Has trouble remembering right/left
- ☐ Has trouble remembering times tables
- ☐ Has trouble differentiating colors
- ☐ Headaches
- ☐ Impatient / restless
- ☐ Impulsive
- ☐ Inappropriate drowsiness
- ☐ Lacks confidence
- ☐ Leaves projects incomplete
- ☐ Letter / number reversal
- ☐ Lies
- ☐ Mood swings
- ☐ Over or under active
- ☐ Poor eye-hand co-ordination
- ☐ Poor handwriting
- ☐ Poor organizational skills
- ☐ Poor reading comprehension
- ☐ Poor reading skills
- ☐ Poor balance
- ☐ Poor spelling
- ☐ Poor arithmetic
- ☐ Poor at sports or rhythmic activities
- ☐ Rests head on arm while working
- ☐ Short attention span
- ☐ Slow in completing work
- ☐ Stops in the middle of a game
- ☐ Test or performance anxiety
- ☐ Timid / shy
- ☐ Phobias / fears (explain)

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☐ Speech difficulties (explain)

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☐ Other: (explain)

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