

BIT BEHAVIORAL CHECK LIST

NAME: _____ DATE: _____

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

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