

BIT Behavioral Checklist

NAME: _____

DATE: _____

*Please check anything that **might** apply. Put **two** checks against anything which is especially important.*

<input type="checkbox"/>	Accident prone
<input type="checkbox"/>	Anxiety / nervousness
<input type="checkbox"/>	Clumsy
<input type="checkbox"/>	Daydreams excessively
<input type="checkbox"/>	Difficulty budgeting time
<input type="checkbox"/>	Difficulty concentrating
<input type="checkbox"/>	Difficulty focusing eyes
<input type="checkbox"/>	Difficulty following directions
<input type="checkbox"/>	Difficulty giving directions
<input type="checkbox"/>	Difficulty telling time
<input type="checkbox"/>	Difficulty with mathematics
<input type="checkbox"/>	Dizziness/vertigo/balance problems
<input type="checkbox"/>	Emotional issues
<input type="checkbox"/>	Eyestrain/rubs eyes a lot
<input type="checkbox"/>	Fear of speaking in front of a group
<input type="checkbox"/>	Has trouble remembering directions
<input type="checkbox"/>	Has trouble remembering months of the year
<input type="checkbox"/>	Has trouble remembering names
<input type="checkbox"/>	Has trouble remembering right/left
<input type="checkbox"/>	Has trouble remembering times tables
<input type="checkbox"/>	Has trouble differentiating colors
<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Impatient/restless
<input type="checkbox"/>	Impulsive
<input type="checkbox"/>	Inappropriate drowsiness/tired all the time
<input type="checkbox"/>	Lacks confidence
<input type="checkbox"/>	Leaves projects incomplete
<input type="checkbox"/>	Letter/number reversal
<input type="checkbox"/>	Lies
<input type="checkbox"/>	Mood swings

<input type="checkbox"/>	Over or under active
<input type="checkbox"/>	Poor eye-hand coordination
<input type="checkbox"/>	Poor handwriting
<input type="checkbox"/>	Poor organizational skills
<input type="checkbox"/>	Poor reading comprehension
<input type="checkbox"/>	Poor reading skills
<input type="checkbox"/>	Poor spelling
<input type="checkbox"/>	Poor at sports or rhythmic activities
<input type="checkbox"/>	Rests head on arm while working
<input type="checkbox"/>	Short attention span
<input type="checkbox"/>	Slow in completing work
<input type="checkbox"/>	Stops in the middle of a game
<input type="checkbox"/>	Test or performance anxiety
<input type="checkbox"/>	Timid/shy
<input type="checkbox"/>	Trouble finding balance in life between work/ family or home/friend/school
<input type="checkbox"/>	Allergies (feel tired or hyper after eating)
<input type="checkbox"/>	Phobias/fears (explain)
<input type="checkbox"/>	
<input type="checkbox"/>	Speech difficulties (explain)
<input type="checkbox"/>	
<input type="checkbox"/>	TMJ/orthodontics
<input type="checkbox"/>	
<input type="checkbox"/>	Other (explain)
<input type="checkbox"/>	