

BEHAVIORAL CHECK LIST

NAME: _____

DATE: _____

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

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Accident prone <input type="checkbox"/> Allergies (feel tired or hyper-active after eating) <input type="checkbox"/> Clumsy <input type="checkbox"/> Constipated • <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"/> Dizziness / vertigo / balance problems <input type="checkbox"/> Eye strain / 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 • <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"/> <u>Over</u> or under active <input type="checkbox"/> Poor eye-hand co-ordination <input type="checkbox"/> Poor handwriting | <ul style="list-style-type: none"> • <input type="checkbox"/> Poor organizational skills • <input type="checkbox"/> Poor reading comprehension <input type="checkbox"/> Poor reading skills <input type="checkbox"/> Poor balance • <input type="checkbox"/> Poor spelling • <input type="checkbox"/> Poor arithmetic <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"/> Phobias / fears (explain) <p>_____</p> <p>_____</p> <input type="checkbox"/> Speech difficulties (explain) <p>_____</p> <p>_____</p> <input type="checkbox"/> Medications currently taking (explain) <p>_____</p> <p>_____</p> <input type="checkbox"/> Antibiotic/ Steroid history (explain) <p>_____</p> <p>_____</p> <input type="checkbox"/> Wear glasses or contact lenses? <p>_____</p> <input type="checkbox"/> Other: (explain) <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|--|--|