BOSTON *Brain* INTEGRATION

BIT BEHAVIORAL CLIENT CHECKLIST

NAME: _____ **DATE:** _____

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

- ❑ Accident prone
- ❑ Anxiety/nervousness
- ❑ Clumsy
- ❑ Daydreams excessively
- ❑ Difficulty budgeting time
- ❑ Difficulty concentrating
- ❑ Difficulty focusing eyes
- ❑ Difficulty following directions
- ❑ Difficulty giving directions
- ❑ Difficulty telling time
- ❑ Difficulty with Mathematics
- ❑ Difficulty with Sports
- ❑ Dizziness/vertigo/balance problems
- ❑ Emotional issues
- ❑ 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/tired all the time
- ❑ Lacks confidence
- ❑ Leaves projects incomplete
- ❑ Letter/number reversal
- ❑ Lies
- ❑ Mood swings
- ❑ No sense of rhythm
- ❑ Over or under active (circle which one)
- ❑ Poor eye-hand coordination
- ❑ Poor handwriting
- ❑ Poor organizational skills
- ❑ Poor reading comprehension
- ❑ Poor reading skills
- ❑ Poor spelling
- ❑ 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
- ❑ Trouble finding balance in life between work/family or home/friends/school

- ❑ Allergies (feel tired or hyper after eating)

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  _____

- ❑ Phobias/fears (explain)

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- ❑ Speech difficulties (explain)

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- ❑ TMJ/orthodontics

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- ❑ Other (explain)

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