**BIT Parental Functional Assessment Checklist**

**CHILDREN**

**Name: Date:**

**Instructions:** Please rate each symptom/condition by checking the appropriate box to the right. Once complete, please mail this form back to your practitioner. Please make sure this is completed and returned several days prior to your first session, as this allows your practitioner time to review your concerns. This is lengthy, but it gives us a lot of great information and allows us to track improvements over time. (We will score this on our end.)

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| **Symptoms & Concerns** | **No Difficulty** | **Little Difficulty** | **Moderate Difficulty** | **Much Difficulty** | **Extreme Difficulty** |
| **PHYSICAL** |  |  |  |  |  |
| Allergies/ Sensitivities\* |  |  |  |  |  |
| Balance Issues (other than dizziness) |  |  |  |  |  |
| Clumsy/ Accident Prone |  |  |  |  |  |
| Concussions |  |  |  |  |  |
| Constipation/Digestive Issues |  |  |  |  |  |
| Daydreams Excessively |  |  |  |  |  |
| Dizziness/ Vertigo |  |  |  |  |  |
| Difficulty Focusing Eyes |  |  |  |  |  |
| Drowsiness/ Fatigue |  |  |  |  |  |
| Eye Strain/ rubs eyes a lot |  |  |  |  |  |
| Headaches |  |  |  |  |  |
| Poor Eye-Hand Coordination |  |  |  |  |  |
| Poor Overall Coordination |  |  |  |  |  |
| Poor Handwriting |  |  |  |  |  |
| Poor at sports or rhythmic activities |  |  |  |  |  |
| Sensory Issues (tastes, textures, etc.) |  |  |  |  |  |
|  |
| **EMOTIONAL** |  |  |  |  |  |
| Anxiety/ Nervousness |  |  |  |  |  |
| Emotional Reactivity and/or poor emotional regulation |  |  |  |  |  |
| Impatient/ Restlessness |  |  |  |  |  |
| Impulsive |  |  |  |  |  |
| Lack of confidence or Self worth |  |  |  |  |  |
| Lies |  |  |  |  |  |
| Mood Swings/ Tantrums |  |  |  |  |  |
| Overthinks |  |  |  |  |  |
| Test or Performance Anxiety |  |  |  |  |  |
| Timid/ Shy |  |  |  |  |  |
| Phobias/ Fears \* |  |  |  |  |  |
| Unusually Emotionally sensitive |  |  |  |  |  |
|  |
| **EXECUTIVE FUNCTIONS** |  |  |  |  |  |
| Difficulty Budgeting Time |  |  |  |  |  |
| Difficulty Concentrating |  |  |  |  |  |
| Difficulty Following Instructions |  |  |  |  |  |
| Difficulty with geographical Directions |  |  |  |  |  |
| Difficulty maintaining relationships with other children |  |  |  |  |  |
| Difficulty Remembering Names |  |  |  |  |  |
| Difficulty Remembering Left/Right |  |  |  |  |  |
| Difficulty starting or completing tasks and projects |  |  |  |  |  |
| Fear of speaking in front of groups |  |  |  |  |  |
| Lacks balance b/t life/school/family/friends/ self care |  |  |  |  |  |
| Over or under active |  |  |  |  |  |
| Poor Organizational Skills |  |  |  |  |  |
| Short attention span |  |  |  |  |  |
| Slow in completing work |  |  |  |  |  |
| Stops in the middle of a game |  |  |  |  |  |
| Unable to see the "big picture"  or break larger projects into small tasks. |  |  |  |  |  |
|  |
| **LEARNING** |  |  |  |  |  |
| Difficulty with math  |  |  |  |  |  |
| Difficulty learning times tables |  |  |  |  |  |
| Difficulty remembering months of year |  |  |  |  |  |
| Difficulty telling time |  |  |  |  |  |
| Letter/ Number reversal |  |  |  |  |  |
| Poor reading comprehension |  |  |  |  |  |
| Poor reading skills |  |  |  |  |  |
| Rests head on arm while working |  |  |  |  |  |
| Speech Difficulties |  |  |  |  |  |
| Spelling Difficulties |  |  |  |  |  |
| **Column Totals** |  |  |  |  |  |
| **Grand TOTAL** |  |  |  |  |  |

**Allergies & Sensitivities**

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**Fears & Phobias**

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|  |

**OTHER**

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