CHILD:_____ ID:_ _ _ _ DATE:__/__/

INFORMANT: MOM=1; DAD=2; GRANDMA =3; OTHER=4; SPECIFY:

HEALTH AND BEHAVIOR INVENTORY (Parent current version)

Directions: Below is a list of problems that your child may or may not have. For each problem, please rate your child based on the last week using the scale below.

O = Never, 1 = Rarely, 2 = Sometimes, 3 = Often

1. has trouble sustaining attention	0	1	2	3
2. is easily distracted	0	1	2	3
3. has difficulty concentrating	0	1	2	3
4. has problems remembering what he/she is told	0	1	2	3
5. has difficulty following directions	0	1	2	3
6. tends to daydream	0	1	2	3
7. gets confused	0	1	2	3
8. is forgetful	0	1	2	3
9. has difficulty completing tasks	0	1	2	3
10. has poor problem-solving skills	0	1	2	3
11. has problems learning	0	1	2	3
12. has headaches	0	1	2	3
13. feels dizzy	0	1	2	3
14. has a feeling that the room is spinning	0	1	2	3
15. feels faint	0	1	2	3
16. has blurred vision	0	1	2	3
17. has double vision	0	1	2	3
18. experiences nausea	0	1	2	3
19. gets tired a lot	0	1	2	3
20. gets tired easily	0	1	2	3

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