

### **PSYCHOPHARMACOLOGY**

# A-B-C Data for Behaviors of Concern

325 Sharon Park Drive, Unit 647 Menlo Park, CA 94025

(800) 806-5718

## Caretaker/Teacher interview or direct observation (Circle one)

	Does the child display this bx?	Antecedent What happens before? Motivating or Abolishing Operation	Behavior What does it look like?	Consequence What happens after?	Frequency, Duration, Intensity
Self- stimulatory (Hand flapping, lining up, vocal sounds, etc.)	Yes/No				F: D: I: F: D: I: I:
Self- injurious  (Banging head, biting self, poking eyes, pulling out hair, etc.)	Yes/No				F: D: I:  F: D: I: I:
Unsafe behaviors to self  (Running away, climbing on furniture, etc.)	Yes/No				F: D: I: F: D: I: I:

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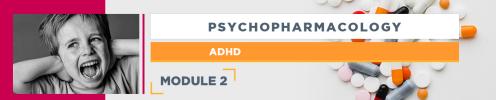
this bx?before?like?after?InterestUnsafe behaviorsYes/NoF:D:	ation, ensity
Unsafe Yes/No F: behaviors D:	ensity
behaviors D:	,
■ to atheres	
to others I:	
(Hitting,	
kicking,	
throwing,	
etc.)	
F:	
D:	
Ritualistic Yes/No F: Behaviors D:	
I:	
(Wearing	
the same F:	
clothes D:	
every day, I:	
focused on	
the same F:	
topic, etc.)	
Any other F:	
behaviors D:	
of concern I:	
F:	
D:	
F:	
D:  I:	

#### **PSYCHOPHARMACOLOGY**

ADHD



reinforcement/punishment strategies or behavioral management strategies have been used in ne past? (Make note of perceived effective less) 2. What is your child's communication system? (PECS, AAC, verbal, combination, etc.) 3. What are some preferred foods, toys, activities? 4. Any known environmental triggers for behavior that we should be aware of? (i.e. loud sounds, animals, etc.) 5. Any concerns with fine or gross motor function? 6. What are some strong academic/cognitive areas? Areas for improvement?





7.	What are your child's sensory needs/preferences?
8.	What is your child's toileting routine?
9.	What is your child's sleep routine? Any sleep disturbances or concerns?
10.	What is your child's diet like? (preferred foods, restricted diet, etc.)
11.	Does your child have any medical concerns that we should be aware of? (seizures, allergies, deafness etc.)

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Q	(800)	806-5718
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Carried Marie Control	
15 500	ur shild surrently take any modifications? (Mod. dosogo froguency)
DIZ. LIDER VU	ur <b>ning curre</b> ntly take any medicatrons, (ivied, dosage, frequency)
	unchild currently take any medications? (Med, dosage, frequency)

What beha	viors do you want to see? (	Skills added, behaviors reduced)
Wha	is most important to you	to address during therapy?
ehavior goals:		
Communication sk	ls:	
ocial skills/Play sk	ls:	
elf-Help:		



5.	Other relevant factors that would make a socially significant impact on your family's life:
6.	Other Notes:
	Other Questions
1.	When was your child diagnosed? By who?
2.	What school does your child go to? Type of classroom? IEP? SLP/OT services at school?
3.	Does your child receive any outside services (SLP, OT, psychiatry, etc.)











4.	what is your preferred method of communication?
5.	Schedule preferences:
6.	Any specific qualities you think are important for someone working with your child to have?