Special Learning, Inc.
www.special-learning.com
325 Sharon Park Drive, Unit 647
Menlo Park, CA 94025
(800)806-5718

A-B-C Data for Behaviors of Concern

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:
					F: D: I:
Self-injurious (Banging head, biting self, poking eyes, pulling out hair, etc.)	Yes/No				F: D: I:
					F: D: I:
					F: D: I:
Unsafe behaviors to self (Running away, climbing on furniture, etc.)	Yes/No				F: D: I:
					F: D: I:
					F: D: I:

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	Does the child display this bx?	**Antecedent** What happens before?	**Behavior** What does it look like?	**Consequence** What happens after?	**Frequency, Duration, Intensity**
Unsafe behaviors to others (Hitting, kicking, throwing, etc.)	Yes/No				F: D: I:
					F: D: I:
					F: D: I:
Ritualistic Behaviors (Wearing the same clothes every day, focused on the same topic, etc.)	Yes/No				F: D: I:
					F: D: I:
					F: D: I:
Any other behaviors of concern					F: D: I:
					F: D: I:
					F: D: I:

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1. What reinforcement/punishment strategies or behavioral management strategies have been used in the past? (Make note of perceived effectiveness)

_____

_____

_____

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?

_____

_____

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_____

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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12. Does your child currently take any medications? (Med, dosage, frequency)

_____

_____

_____

What behaviors do you want to see? (Skills added, behaviors reduced)

What is most important to you to address during therapy?

1. Behavior goals:

_____

_____

_____

_____

2. Communication skills:

_____

_____

_____

_____

3. Social skills/Play skills:

_____

_____

_____

_____

4. Self-Help:

_____

_____

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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.)

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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?