

# FUNCTIONAL BEHAVIOR ASSESSMENT

**Name:**

**Date:**

**Age:**

**Informant:**

**Relation to Subject:**

**Diagnoses:**

**Physical or Sensory Handicaps:**

**Communication Skills:**

## DISCRIPTION OF BEHAVIORS:

List Behaviors of Concern Be specific (hitting face, not self abuse)	Frequency and Duration: How often and for how long	Intensity of Behavior: Damage done, injury involved, etc.	How Long Has Behavior Been Occurring

Do any of the above behaviors occur together or in a chain (e.g. biting self and hitting others)?

Of the above behaviors, which behavior is of greatest concern (what we need to address first)?

Under what circumstances does the behavior occur? What events seem to trigger the behavior?

Does behavior occur at specific times during the day?

What times/circumstances during the day is the behavior less likely to occur?

With whom is the behavior more likely to occur; less likely to occur?

**Antecedent Conditions:** Check any of the following that present (or trigger) the behavior:

- |   |   |
|---|---|
| <input type="checkbox"/> wants something  | <input type="checkbox"/> doesn't understand expectations    |
| <input type="checkbox"/> told cannot have something   | <input type="checkbox"/> doesn't know how to respond        |
| <input type="checkbox"/> something is taken away  | <input type="checkbox"/> transitions                        |
| <input type="checkbox"/> not receiving attention  | <input type="checkbox"/> pain/discomfort                    |
| <input type="checkbox"/> staff/parent withdraws attention                                   | <input type="checkbox"/> something scares him/her           |
| <input type="checkbox"/> when attention is turn to others                                   | <input type="checkbox"/> noisy, active settings             |
| <input type="checkbox"/> behavior stops soon after attention or<br>desired item is obtained | <input type="checkbox"/> peers are pestering him/her        |
| <input type="checkbox"/> requested to do something  | <input type="checkbox"/> others are disruptive              |
| <input type="checkbox"/> frustrated with difficult task                                     | <input type="checkbox"/> experiencing pain/discomfort       |
| <input type="checkbox"/> pressured into unwanted events                                     | <input type="checkbox"/> difficulty communicating need/want |
| <input type="checkbox"/> someone tries to control or lead his/her activity                  | <input type="checkbox"/> happy/excited with upcoming event  |
| <input type="checkbox"/> asked to stop doing something                                      | <input type="checkbox"/> before, during, or after an outing |
| <input type="checkbox"/> novel/new situations   | <input type="checkbox"/> during group activities            |
| <input type="checkbox"/> unexpected change  | <input type="checkbox"/> riding in car                      |
| <input type="checkbox"/> when left alone or during downtime                                 | <input type="checkbox"/> prior to or during menses          |

Comment, give specifics about conditions check off above:

**Consequences of Behavior:** How do people react to the behavior, what effects does the behavior have on the environment, and what payoffs does the behavior have for the child.

How do you typically respond (intervene) when behavior occurs?

How do others (peers, other adults, etc.) around him respond?

How does person respond when you intervene/redirect?

What interventions have you tried so far?

What techniques have shown some success?

How does person respond when:

Verbally redirected?

Physically redirected?

Behavior is ignored?

Removed from the group?

Ask to restore property disrupted?

Does the person seem to respond better to firm, neutral, or calm direction?

Does person appear to lose control when upset?

Does person respond better to firm, neutral, or calm direction?

What benefits does the person seem to gain from the behavior?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Get out of doing something | <input type="checkbox"/> Avoid/escape unwanted event | <input type="checkbox"/> Get something he/she wants  |
| <input type="checkbox"/> Obtain attention/reaction  | <input type="checkbox"/> left alone                  | <input type="checkbox"/> Gain control                |
| <input type="checkbox"/> Get back at someone        | <input type="checkbox"/> Obtain stimulation          | <input type="checkbox"/> Release tension/frustration |

Other:

## **Communication**

How does person communicate needs and wants?

How does person ask for help?

How does person communicate distress/discomfort?

How does person communicate something they don't want to do?

What might the person be trying to communicate with problem behavior?

## **Social Relations**

How does person interact/get along with:

Peers?

Staff/teachers?

Does person initiate/seek out interactions with others?

What is person general ability in co-regulating in an activity with others?

## **Instructional Skills**

Briefly describe person's attention span/task performance skills (ability to stay on task, complete simple tasks).

Direction following skills?

Frustration tolerance?

Acceptance of criticism?

Most responsive too? \_\_\_ verbal directions \_\_\_ demonstration \_\_\_ picture/visual cues \_\_\_ gesture

Explain best way to give instructions/guide the person

## **Daily Routine (Home)**

Briefly describe participation/skills in following areas:

Self care:

Household tasks:

Leisure interests/activities:

Community outings:

Briefly describe the person's routine during the day:

Morning routine:

Afternoon routine:

Evening routine:

Describe any set routines/rituals that are important for the person.

How does person deal with change in routine/schedule?

What does person do during free time?

What are the person's favorite times during the day?

Will person allow caregiver to structure their time and activity?

Will person follow the lead of caregiver to pattern the activity (or does he/she have to control activity)?

What activities/times during the daily routine is problem behavior most likely to occur?

## **Daily Routine (School)**

What are the person's favorite subjects/activities at school?

What are his/her least favorite subjects/activities at school?

What type of supports does person need to make it through the day (aid, task adaptations, etc.)

What does person's routine look like for the day?

Morning routine:

Afternoon routine:

How does person handle unexpected changes in the classroom?

How does person handle transition times (start of day, transition between activities, cleaning up, etc.)

Does the person use a picture schedule or other types of visual aids in the classroom?

Does person follow the structure (rules and regulations, schedule, etc.) of the classroom well?

What is the best way to teach the person (verbal instructions, written, picture, demonstration, etc.)?

What seems to frustrate the person the most at school?

What part(s) of the daily routine is problem behavior most likely?

## **Strengths and Preferences**

What are the person's strengths? (personal, skills, activities, etc.)

What does person do that is desirable in their routine now (interactions with others, participation in activities, etc). If your job was to "catch him/her being good", what would that be?

What does he/she do well now, that you would like to see them increase during the day?

List three activities (e.g. bathing, playing catch, puzzle, etc.) you can easily engage (do together) with the person?

When person is calm, relaxed, and having fun, what is he usually doing?

When does the child feel the most competent?

What helps the person feel safe and secure (type of physical surroundings, type of activity, the way people interact with him, etc.)

What makes him scared, fearful, and anxious?

What makes the person the happiest?

# Reinforcer Menu

What are the person's likes and desires in the following areas:

## **Food/Liquids**

(Favorite food and drink)

## **Social Interaction**

(praise, hugs, high five, tickle, rough-house, etc)

## **Toys/Objects**

(toys, jewelry, purse, clothing, etc.)

## **Activities**

(music, TV, playing catch, game, etc.)

## **Sensory Stimulation**

(visual, tactile, auditory, moment, etc.)

## **Self-Initiated Behavior**

(Any activity person initiates during free time, including constructive activity and self stimulation)

From preferences listed above which are the strongest, in order of preference?

From preferences above, which can you realistically use to reward good behavior?



## Sensory Checklist

Please check any symptoms that person exhibits

### TACTILE

- Dislikes being touched.
- Resist hugs and kisses.
- Fearful when others approach.
- Withdraws or hits when approached or touched.
- Rubs spot after being touched.
- Exhibits clingy behavior.
- Tries to handle or touch everything/others.
- Resists others holding hand.
- Insists on large personal space.
- Prefers to be in corner, under table, behind furniture
- Likes/dislikes tight clothing.
- Layers clothing
- Pushes up pant legs, sleeves, shirts.
- Strips off clothing.
- Only will wear certain texture of clothing.
- Removes tags, collars, or cuffs
- Frequently adjusts clothing or bedding.
- Insists on something wrapped around wrist, arm, and finger.
- Dislikes being barefoot.
- Insists on being barefoot.
- Walks on toes.
- Spits out/rejects certain food textures.
- Picky eater.
- Resists grooming: face washing, bathing, shaving, hair combing, tooth brushing, and nail cutting.
- High tolerance for pain.
- Over or under sensitive to hot or cold.
- Dislikes wearing hats.
- Graves deep pressure
- Persistent hand to mouth activity.
- Mouths objects or clothing.
- Rubs or plays with spit, feces.
- Persistently has hand in pants or pants pocket.
- Sits on hands/feet
- Pushes or rubs body against objects/walls/people.
- Insists on holding an object in hands.
- Rubs fingers against hand or other fingers.
- Masturbates frequently.
- Self-injurious behavior- Scratches, pinches, rubs, hits/slaps, pulls hair, bites hand/wrist/arm.

Comments:

### PROPRIOCEPTIVE

- Poor muscle tone.
- Weak grip.
- Tires easily
- Passive unless encouraged or assisted.
- Slurred speech.
- Clumsy/awkward
- Awkward getting on and off furniture.
- Overly rough with objects and people.
- Likes to rough house, wrestle.
- Flaps hands, claps, jumps, hops, stamps feet.
- Bites, chews on objects.
- Presses or bangs wrists.
- Climbs in inappropriate places.
- Pushes or leans heavily against people or objects.
- Slams furniture, pounds on wall, throws things.
- Hits, slaps or bangs head.
- Bites self.
- Grinds teeth.
- Butts head or body into things.
- Hits, kicks, pushes objects/others.

Comments:

### VESTIBULAR

- Tenses or becomes irritable when moved.
- Displays gravitational insecurity.
- Poor balance, anxious when moving.
- Drops to floor when anxious or walking distance.
- Hesitant on stairs or ramps.
- Resists being moved by others.
- Resists participating in movement activities.
- Loses balance easily.
- Falls or trips easily.
- Holds onto staff, railing, wall.
- Prefers to sit on the floor.
- Bumps into things, difficulty walking around things
- Rocks frequently.
- Jumps, twirls, spins or bounces.
- Wags head
- Paces, seeks frequent movement.
- Likes to swing.
- Likes movement activities.
- Waves or flicks finger(s) near eyes.
- Has spurts of running.

Comments:

## AUDITORY

- Sensitive to loud noises.
- Can hear frequencies that others cannot.
- Can hear humming of lights, electrical wires, other breathing that others cannot.
- Speaks loudly.
- Hums constantly.
- Covers ears with hands.
- Distracted by background noises.
- Becomes agitated in large group activities.
- Very noisy person.
- Listens to tv or music in loud volume.
- Becomes agitated, disruptive in noisy activities.
- Relaxes when whispered to.
- Loves music
- Frequent ear infection.
- Sometimes “tunes out” or “turns off” from world

Comments:

## VISUAL

- Oversensitive to sunlight.
- Oversensitive to bright lighting
- Squints frequently, looks down a lot.
- Becomes overwhelmed with strong visual changes..
- Flaps hands, usually around eye level.
- Rolls head usually from side to side.
- Enjoys staring at lights.
- Enjoys turning lights on and off.
- Enjoys things that spin or turn.
- Plays with hands in front of eyes.
- Presses eyes with hands, usually at corners.
- Has difficulty moving from one surface to another
- Page turner.
- Loves shiny or reflective objects.
- Loves mirrors.
- Poor eye contact.
- Appears to stare through people.
- Fascinated with fans, things that spin.
- Eyes tire easily/quickly when reading.

Comments:

## SMELL/TASTE

- Smells everything.
- Will not eat without smelling food first.
- Likes to smell other’s hair.
- Loves the smell of cologne or perfume.
- Dislikes smell of cologne or perfume.
- Strong emotional reactions to smells.
- Becomes disorganized, irritable in activities with strong smells.
- Avoids things with strong smells, especially cleanser.
- Frequently smelling hands/fingers.
- Very picky eater.
- Dislikes certain textures or taste of food.
- Loves only strong tasting food.
- Eats only bland food.
- Puts everything in mouth
- Chews on string, clothing, fingers.
- Has many allergies.
- Will spit out foods they do not like.

Comments:

## GENERAL REACTIONS:

- Poor frustration tolerance.
- Needs to control all activity and interaction.
- Inability to delay gratification.
- Poor attention span, distractible.
- Noncompliant, resistant to direction.
- Unpredictable emotional outbursts.
- Constantly moving, difficulty sitting still
- Difficulty with transitions between activities, places, and people.
- Generally anxious, easily upset, disorganized.
- Becomes overwhelmed with high stimulating activities.
- Becomes upset with change in routine.
- Needs rigid schedule.
- Seeks constant attention or reassurance.

Comments:

## Medical/Psychiatric

Acute Medical Problems: (constipation, ear infections, headaches, any acute discomfort)

Chronic Medical Problems: (ulcer, hernia, hypertension, allergies, diabetes, etc.)

Seizures? Type, frequency, duration

Medications:

Negative side effects of medications:

Current Diet:

Problems eating or sleeping:

Psychiatric Diagnosis:

Check any of the following symptoms exhibited:

- |  |   |
|--|---|
| <input type="checkbox"/> Withdrawn, inactive   | <input type="checkbox"/> Displays little interest   |
| <input type="checkbox"/> Frequent mood swings  | <input type="checkbox"/> Periods of over-activity   |
| <input type="checkbox"/> Appears anxious, fearful, apprehensive  | <input type="checkbox"/> Depressed affect   |
| <input type="checkbox"/> Fixed expression, blank stare   | <input type="checkbox"/> Laughs/cries at inappropriate times  |
| <input type="checkbox"/> Overreacts to minor irritations   | <input type="checkbox"/> becomes agitated for no reason   |
| <input type="checkbox"/> Talks fast/loud   | <input type="checkbox"/> Rambles without making sense   |
| <input type="checkbox"/> Jumps from one topic to another   | <input type="checkbox"/> Repeats same statement over and over   |
| <input type="checkbox"/> Complains about imaginary illness   | <input type="checkbox"/> Preoccupied about unrealistic fears  |
| <input type="checkbox"/> Obsesses about others hurting him,<br>talking about him, picking on him, etc. | <input type="checkbox"/> Hears voices   |
| <input type="checkbox"/> Talks about being a someone else<br>(Jesus, movie star, etc.)                 | <input type="checkbox"/> See things that are not there  |
|  | <input type="checkbox"/> Compulsive behaviors (excessive<br>washing, rearranging things, changing<br>Clothes, etc.) |

Other:

Comments: