Functional Behavioral Assessment Questionnaire

Child's Name: _____ Date of Birth: _____ Sex: M F

Person Responding: _____ Date Completed: _____

Primary Caretakers (Please list the family members, teachers, or other individuals who care for your child on a regular basis):

Name	Relationship

Living Arrangement: Please describe your home and community:

_____
_____

Programs and Services: Please list the educational or therapeutic programs (e.g., school, daycare, OT, PT, speech) in which your child is currently participating:

Program/Service	Contact Person	Frequency (how often)

Broad Goals

_____
_____
_____
_____
_____
_____

Medical Issues

Please list any medical or psychiatric diagnoses that your child has received.

_____
_____

Please list any medications your child is taking that could impact his or her behavior.

Medication	Dose	Frequency	Reason	Impact

Please describe any additional medical complications (e.g., asthma, allergies, skin conditions, stomach problems, seizures) that could be affecting your child's behavior.

_____
_____
_____

About how many hours of sleep does your child get each day (including naps)? _____
Does he or she sleep through the night? Yes No

Does your child have any eating habits or dietary restrictions that could affect his or her behavior? If so, please describe.

_____
_____

Behavioral Profile

Child's Strengths: What are your child's greatest strengths (e.g., skills, interests)?

_____
_____
_____

Communication Skills: How does your child communicate his or her needs (please check all that apply)?

	Words	Signs	Gestures	Other
Request attention				
Ask for assistance				
Request toy/object				
Initiate activity				
Avoid a situation				
Take a break/stop				
Say "no" to request				
Indicate discomfort				

Other Skills: Describe your child's ability to perform the following types of skills.

Self-care (e.g., dressing, toileting): _____

Daily living (e.g., household chores): _____

Play/leisure (e.g., using toys, games): _____

Academics (e.g., writing, cutting): _____

Other: _____

Receptive Communication: Give examples of the ways in which your child responds.

Requests or instructions followed: _____

Behaviors imitated: _____

Potential Reinforcers: What does your child like (i.e., if presented with a variety of options or given free time, what would your child choose)?

Attention (e.g., conversation, eye contact, touch)_____

Tangibles (e.g., activities, toys) _____

Sensations (e.g., smells, sights) _____

Problem Behaviors

Behaviors of Concern: What does your child say or do that concerns you most (e.g., aggression toward self or others, property destruction, tantrums, screaming, inappropriate interactions, resistance, off-task behavior)? Estimate how often, long, and severe.

Behavior	Description	Frequency	Duration	Severity
1.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low
2.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low
3.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low
4.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low
5.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low

Which, if any, of these behaviors occur together? _____

In what environments do these behaviors occur? ☐ Home ☐ School ☐ Community

Impact of Behavior: How are your child's behaviors affecting your child's development, or participation in activities or settings? What is the impact on your family?

_____
_____
_____

Previous Interventions: Please list strategies and interventions you have tried to address your child's behavior, when they were used, and their impact (i.e., how they worked).

Intervention Attempted	When	Impact on Behavior

Setting Events: List activities in which your child is most successful and those in which your child has the greatest difficulty.

Most Successful	Most Problematic
_____	_____
_____	_____
_____	_____
_____	_____

Predictability of Events

Is your child's daily schedule consistent (i.e., Do meals, bedtimes, and other daily events occur at the same time and in the same order)? Yes No

Do you feel that your child generally knows what is going to happen (e.g., where the child will be going, when, and with whom)? Yes No

Opportunities for Choice: Please describe the different types of choices your child has the opportunity to make on a regular basis (e.g., what to wear, with whom to play, what activities to do):

_____
_____

Social Influence: With whom is your child's behavior of concern…

Most Likely: _____

Least Likely: _____

Possible Triggers: What impact would you expect the following situations to have on your child's behaviors of concern?

Situation	More Likely	No Impact	Less Likely	Notes
Asked to do a difficult task				
Told no or to stop activity				
Attention is withdrawn				
Change in routine/schedule				
Loud or chaotic situations				
Required to wait/delayed				
Other situations that are particularly difficult:				

Possible Functions: What are the most common outcomes of your child's behaviors of concern (e.g., does your child get attention or items, avoid demands or situations)?

Behavior	What does your child get?	What does your child avoid?
1.		
2.		
3.		
4.		
5.		

Other Issues: Please feel free to describe other issues you feel could be influencing your child's behavior.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Attach additional notes or copies of reports as needed.

Adapted from O'Neill, R.E., Horner, R. H., Albin, R.W., Storey, K., & Sprague, J. R.. (1990). *Functional analysis of problem behavior: A practical guide.* Sycamore, IL: Sycamore Publishing.