Integrated Behavioral Health Solutions, Inc.

Child's name:_____

_____

(First) (Middle) (Last)

Date of Birth: _____ ___ Male ___ Female

Diagnosis:_____

Other Conditions: _____

Race: ___ Caucasian ___ African American ___ Hispanic ___ Asian ___ Other

Parent- Guardian information

Mother / Legal Guardian:_____

Address: _____

Home phone: (___) _____. Work phone:(___) _____ Cell: (___)_____

Email: _____

Occupation: _____Title:_____

Employer: _____

Do you give permission for information about your child to be sent to you over the internet?

Yes No Initials:_____

Father / Legal Guardian:_____

Address: _____

Home phone: (___) _____ Work phone: (___) _____ Cell: (___) _____

Email: _____

Occupation: _____ Title:_____

Employer: _____

Do you give permission for information about your child to be sent to you over the internet?

Yes No Initials:_____

Child lives with (check all that apply) __ Father __ Mother __ Other (specify)

Siblings

Name: _____ Age: _____ M / F In home: Y / N
Name: _____ Age: _____ M / F In home: Y / N
Name: _____ Age: _____ M / F In home: Y / N
Name: _____ Age: _____ M / F In home: Y / N

Emergency Contacts

Name: _____ Relation to child: _____ Phone (___)
_____

Name: _____ Relation to child: _____ Phone (___)
_____

Primary Doctor's Name: _____ Phone (___)_____

Medical Information

~~Was your child breast~~ fed? Yes No

If 'No' what infant formula did you use and for how long?

_____

_____

_____

Did your child receive any childhood vaccinations? Yes No.

If 'Yes' provide details below.

_____

_____

_____

Did your child have frequent ear infections? Yes No

If 'Yes", approximately how many courses of antibiotics did your child receive before the age of 3?

_____

Does your child take any medications at this time? Yes No

Medication Since Daily dosage Prescribed for

_____

_____

_____

Allergies

Does your child have any allergies? Yes No

Environmental:

Food:

Medication:

Hearing and vision

Does your child have any hearing problems? If so, explain

Does your child have any vision problems? If so, explain

Eating and drinking

Does your child refuse any fluids? If so, explain

Does your child refuse food? If so, explain

Toilet training

Does your child use the toilet appropriately? If not, explain

How would you describe your child's personality (circle as many as you like)?

calm	energetic	moody	cranky	pleasant
bossy	submissive	friendly	shy	anxious
sad	happy	oppositional	independent	dependent
opinionated	scattered	organized	angry	carefree
creative	passive-aggressive	impatient	unmotivated	helpful

Expectations

What are your immediate goals for your child?

_____
_____
_____

How are we to assist you in reaching these goals?

_____
_____
_____

Parent Involvement / Commitment

What level of commitment are you willing to make at home in order for your child to achieve these goals?

_____
_____
_____

Educational Services
Describe your child's current classroom/school setting

_____
_____
_____

Describe your child's current home program

_____

_____

_____

_____

Describe any other learning history that your child has had (past home program or school settings)

_____

_____

_____

_____

Do you currently have a behavioral or educational consultant for your child's home or school program? If so please provide the following information (include any lead teachers or agency provided supervisors):

Name	Agency	How often

Do you currently have a speech therapist, occupational therapist or physical therapist working with your child?

Name	Speech /OT / PT	How often

_____
_____
_____
_____

Please answer the following questions. Your answers will allow us to gage your child's current skill levels which will help us decide on further treatment.

VERBAL BEHAVIOR – THE BEHAVIORAL LANGUAGE ASSESSMENT FORM

Mark L. Sundberg and James W. Partington

_____
_____

Student: _____ Date of birth: _____ Today's date:_____
_____
_____
_____

SKILLS		1. COOPERATION	2. REQUESTING	3. MOTORIMITATION	4. VOCALPLAY	5. VOCALIMITATION	6. MATCH-TO-SAMPLE	7. RECEPTIVE	8. LABELING	9. RECEPTIVEBYFCC	10. CONVERSATION	11. LETTERS&NUMBERS	12. SOCIALINTERACTIONS
	5												
	4												
	3												
	2												

	1												

1. COOPERATION WITH ADULTS

How is it to work with your child?

- Uncooperative, always avoids work, engages in disruptive behavior
- Will do only one, brief and easy response for something he really wants
- Will do 5 responses without disruptive behavior
- Will work for 5 min without disruptive behavior
- Will work well for 10 min at a table without disruptive behavior

2. REQUESTING (MANDS)

How does your child indicate wants and needs?

- Does not ask for things he wants; or engages in disruptive behavior to get what he wants
- Pulls people, points, or stands by things he wants
- Uses 1 – 5 words, signs or pictures to ask for things he wants
- Uses 5 – 1- words, signs or pictures to ask for things he wants
- Frequently asks for things he wants using 10 or more words, signs, or pictures.

3. MOTOR IMITATION

Does your child imitate motor actions?

- Does not imitate anybody's motor movements
- Imitates a few gross motor movements modeled by others
- Imitates several gross motor movements on request
- Imitates several fine and gross motor movements on request
- Easily imitates any fine or gross motor movements, often spontaneously

4. VOCAL PLAY

Does your child spontaneously make sounds or say words?

- Does not make any sounds (mute)
- Makes a few speech sounds at a low rate
- Makes many speech sounds with varied intonations
- Frequently makes many speech sounds with varied intonations and says a few words
- Vocalizes frequently and says many understandable words

5. VOCAL IMITATION (ECHOICS)

Does your child repeat sounds or words?

- Does not repeat any sounds or words
- Repeats a few specific sounds or words
- Repeats or closely approximates several sounds or words
- Repeats or closely approximates many different words
- Clearly repeats any word, or even simple phrases

6. MATCHING-TO-SAMPLE

Does your child match objects, pictures and designs to presented samples?

- Does not match any objects or pictures to a sample
- Matches 1 or 2 objects or pictures to a sample
- Matches 5 to 10 objects or pictures to a sample
- Matches 5 to 10 colors, shapes, or designs to a sample
- Matches most items and matches 2 to 4 block designs

7. RECEPTIVE (UNDERSTANDING)

Does your child understand any words and follow directions?

- Does not understand any words
- Follows a few instructions related to daily routines
- Follows a few instructions to do actions or to touch items
- Follows many instructions and points to at least 25 items
- Points to at least 100 items, actions, persons, or adjectives

8. LABELING

Does your child label or verbally identify any items or actions?

- Can not identify any items or actions
- Identifies 1 – 5 items or actions
- Identifies 6 – 15 items or actions
- Identifies 16 – 50 items or actions
- Identifies more than 100 items or actions and says short sentences

9. RECEPTIVE BY FUNCTION, FEATURE, AND CLASS

Does your child identify items when given information about those items?

- Does not identify items based on information about them
- Identifies a few items when given synonyms or common functions
- Identifies 10 items given 1 of 3 functions or features
- Identifies 25 items given 4 functions, features, or classes
- Identifies 100 items given 5 functions, feature or classes

10. CONVERSATIONAL SKILLS (INTRAVERBALS)

Does your child fill in missing words or answer questions?

- Does not fill in missing words or parts of songs
- Fills in a few missing words or provide animal sounds
- Fills in 10 non-reinforcing phrases or answer at least 10 simple questions
- Fills in 20 phrases or can answer 20 questions with variation
- Answers at least 30 questions with variation

11. LETTERS AND NUMBERS

Does your child know any letters, numbers or written words?

- Does not identify any letters, numbers or written words
- Identifies at least 3 letters or numbers
- Identifies at least 15 letters or numbers
- Reads at least 5 words and identifies 5 numbers
- Reads at least 25 words and identifies 10 numbers

12. SOCIAL INTERACTION

Does your child initiate and sustain interactions with others?

- Does not initiate interactions with others
- Physically approaches others to initiate an interaction
- Readily asks adults for things he wants
- Verbally interacts with peers following prompts
- Regularly initiates and sustains verbal interactions with peers

EVALUATION OF REACTIONS TO DIFFERENT SENSORY STIMULI

<u>AUDITORY STIMULI (SOUND)</u>

- How does your child respond to:

- loud sounds
- soft sounds
- expected sounds
- unexpected sounds

- How does your child respond:

- when you vary the pitch of your voice

- low pitch
- high pitch
- male or female voice

- Does your child speak at an appropriate volume? Does the volume change dependent upon the situation?

- How does your child respond to music? Does (s)he try to sing along with songs?

- Can your child imitate tapping patterns on a drum or xylophone? Can (s)he repeat the correct number of taps or the tap rhythm?

- How many syllables are there in the sentences that your child consistently imitates?

- How does your child respond to 'talking toys'? What does (s)he do with them when left alone?

- Can your child fill-in the blanks in rhyming books or songs without great difficulty?

VISUAL STIMULI (VISION)

- Can your child identify what is on a photograph?

- How does (s)he respond to line drawings? If you vary the contrast of the colors in the line drawings (brown on tan vs. black on white), or highlight the background, does (s)he respond differently?

- Does your child respond to a small part of a picture rather than to the picture as a whole?

- How does your child behave under fluorescent lights, bright lighting and soft lighting?

- How does your child react to visual stimulation when (s)he is moving (in a car)

- Does your child enjoy looking at spinning or moving objects?

- Does your child complete puzzles? If so, what kind? Can (s)he put puzzles together upside down?

- Does (s)he take toys apart and does (s)he put them back together again?

- Does your child know how to get to different places? Can (s)he find familiar objects after they have been moved?

VESTIBULAR STIMULI (MOVEMENT, BODY IN SPACE, TOUCH)

- Does your child always move, or does (s)he tend to stay in one place?

• Does (s)he do the same thing over and over again, or not?

• Does your child like swinging, spinning or dancing in your arms?

• Does your child react differently to sudden movements as opposed to slow, steady movements? If so, how?

• Does your child prefer small spaces? Large spaces?

• Does your child walk on top of objects rather than around them?

• Does your child react to different textures in clothing or toys? If so, what does (s)he like and what does (s)he not like?

• Does your child respond differently to hugs as opposed to light touches. If so, how?

• Does your child respond differently to a slow steady massage as opposed to short, staccato touches?

• Does your child respond differently to touches on different parts of his body? If so, what does (s)he like and what does (s)he not like?

• Does your child brush his teeth and wash his face? Does (s)he often put things in his mouth?

• Does your child frequently manipulate objects or body parts?

• Can your child do different things in order to complete a task?

• Is your child's overall muscle tone floppy or stiff? Does this change when (s)he wants to get something?

GUSTATORY STIMULI (TASTE)

• Does your child eat a wide variety of flavors of foods?

• Does (s)he appear to prefer spicy, salty, sweet or bland foods?

• Does your child ever lick or mouth items before interacting with them?

SMELL

• Is your child sensitive to perfumes, cleaning agents or other chemicals?

• Does your child enjoy particular smells? If so, which ones?

• Does your child frequently smell things before (s)he does anything with them?

PROBLEM BEHAVIORS

For each of the problem behaviors describe the situation in which it occurs, what it looks like, how often it happens, for how long and what happens afterwards.

• Situation:
_____

Behavior :
_____

What does it look like:
_____

How often does it happen:_____

How long does it last:_____

Is it really bad?:_____

What does (s)he get?:
_____

What does (s)he avoid?:
_____

HOW EFFICIENT IS THE PROBLEM BEHAVIOR? (Efficiency is a function of a) how easy it is to do b) the size and frequency of the pay-off and, c) how quickly s(he) gets it).
_____

Problem since:
_____

Previous treatment:
_____

Did it work:
_____
_

• Situation:
_____

Behavior :

_____

What does it look like:

_____

How often does it happen:

_____

How long does it last:

_____

Is it really bad?:

_____

What does (s)he get?:

_____

What does (s)he avoid?:

_____

HOW EFFICIENT IS THE PROBLEM BEHAVIOR? (Efficiency is a function of a) how easy it is to do b) the size and frequency of the pay-off and, c) how quickly s(he) gets it).

_____

Problem since:

_____

Previous treatment:

_____

Did it work:

_____

_

- Situation:

_____

Behavior :

_____

What does it look like:

_____

How often does it happen:

_____

How long does it last:

_____

Is it really bad?:

_____

What does (s)he get?:

_____

What does (s)he avoid?:

_____

HOW EFFICIENT IS THE PROBLEM BEHAVIOR? (Efficiency is a function of a) how easy it is to do b) the size and frequency of the pay-off and, c) how quickly s(he) gets it).

_____

Problem since:

_____

Previous treatment:

_____

Did it work:

_____

_

• Do some of these behaviors sometimes occur together? Do they occur simultaneously? In a particular order? Under the same circumstances?

_____

_____

• ECOLOGICAL EVENTS THAT MAKE IT MORE LIKELY FOR PROBLEM BEHAVIORS TO HAPPEN.

• Medical or physical conditions that may affect behavior (e.g. asthma, allergies, rashes, sinus infections, seizures, problem related to menstruation)

_____

• Sleep patterns that may affect behavior.

_____

• Eating routines and diet that may affect behavior.

_____

• Daily schedule. Check the boxes to show whether (s)he enjoys or does not enjoy the particular activity.

		Enjoys	Does not
7:00	_____	☐	☐
8:00	_____	☐	☐
9:00	_____	☐	☐
10:00	_____	☐	☐
11:00	_____	☐	☐
12:00	_____	☐	☐
1:00	_____	☐	☐
2:00	_____	☐	☐
3:00	_____	☐	☐
4:00	_____	☐	☐
5:00	_____	☐	☐
6:00	_____	☐	☐
7:00	_____	☐	☐
8:00	_____	☐	☐

• Are these activities predictable in terms of when they will take place, what will happen, with whom and for how long?

_____

• Is (s)he allowed to choose among activities and events? (e.g. food, clothing, companions, leisure activities).

_____

• How many other persons are usually around (staff, classmates). Does (s)he typically seem uncomfortable in situations that are more crowded and noisy?

_____

• What is the pattern of staffing support (1:1, 2:1) that (s)he receives at home and in school? Do you think that the number of staff, the training of staff, or their social interactions with your child affect problem behaviors?.

_____

• SPECIFIC EVENTS THAT MAKE IT 'LIKELY' OR 'LESS LIKELY' THAT THE BEHAVIORS WILL HAPPEN.

• Time of day. When are the behaviors likely to happen?

Likely:

_____

Less likely:

_____

• Settings. Where are the behaviors likely to take place?

Likely:

_____

Less likely:

_____

• People. In whose presence are the behaviors likely to occur?

Likely:

_____

Less likely:

_____

• Activity. What activities make it likely that the behaviors will happen?

Likely:

_____

Less likely:

_____

• Are there any particular situations or events not discussed above that sometimes seem to cause the behaviors? Demands, lights, noises, clothing?

_____

• Is there anything in particular that you could do to make the behavior happen?

_____

• Do you think problem behavior would happen if ……...

• You asked him/her to perform a difficult task:

_____

• You interrupted a desired activity, such as playing games or eating ice cream:

_____

• You unexpectedly changed his/her typical routine:

_____

• (S)he wanted something, but can not get it (e.g. food item on a shelf).

_____

• You did not pay attention to him/her or left him/her alone for some time:

_____

• WHAT SHOULD YOU DO AND WHAT SHOULD YOU NOT DO WHILE WORKING WITH YOUR CHILD?

• What should you do to increase the likelihood of a productive interaction?

_____

_____

_____

• What should you not do to increase the likelihood of a productive interaction?

_____

_____

_____

OTHER INFORMATION THAT YOU WOULD LIKE TO SHARE WITH US

_____