

BEHAVIOR INTENSIVE YOUTH FORM

Youth Name: _____ Date: _____

Facility: _____ Completed By: _____

DOB: _____ Commitment Youth: Yes No Unknown

Reason for Referral: _____

History of Behavior Services

Does this youth have a behavior plan or did he/she receive Applied Behavior Analysis services either their program or in the past?

Yes No Don't know

If yes... Did you attach the FBA or behavior plan?

Yes No BCBA Name & Contact Information: _____

Behavior(s) exhibited by youth (Check all that apply)

Physical Aggression *if so: Towards staff* *Towards youth*

Property Destruction Refusing Hygiene Flooding Inappropriate Urination/Defecation

Excessive Verbal Aggression/Threatening Staff Fecal Smearing Sexually Inappropriate Behaviors

Refusing to Go to Room Refusing to Leave Room Self-Injurious Behaviors

Other: _____

How often do the behaviors occur?

Weekly 2-4 times a week Daily
How many times a day? 1-2 3-5 5 or more

Is there a certain time of day or an activity that is usually going on when the behavior happens?

Time of day Problem Behaviors typically occur:

AM (6:30 am – 12:00 pm) PM (12:00 pm – 9:00pm) Over night: (9:00 pm – 6:30 am)

Activities/Tasks going on when problem behaviors typically occur:

School Showers Group Mental Health Counseling Bedtime

Rec Wake-up Mealtimes Other: _____

BEHAVIOR INTENSIVE YOUTH FORM

Why do the behaviors appear to be happening? (Check all that apply)

- | | |
|--|---|
| For Attention <input type="checkbox"/> | When asked to do something they don't want to do <input type="checkbox"/> |
| To get something he/she wants <input type="checkbox"/> | When he/she is told "no" <input type="checkbox"/> |
| When certain people are around <input type="checkbox"/> | He/She appears to enjoy doing the behavior <input type="checkbox"/> |
| When he/she is in their room alone <input type="checkbox"/> | No reason <input type="checkbox"/> |
| When they are in front of large group of peers <input type="checkbox"/> | When he/she gets in trouble <input type="checkbox"/> |
| When he/she receives a consequence they don't like <input type="checkbox"/> | When he/she is in confinement or behind a door <input type="checkbox"/> |
| When he/she is given work to complete <input type="checkbox"/> | Someone else is getting something he/she wants <input type="checkbox"/> |
| When he/she transitions from a preferred to non-preferred task/activity <input type="checkbox"/> | |

Please describe what the behavior(s) looks like and provide any other information you think may be important for the team to know: Example: "Self-Injurious Behavior = superficially scratching himself with his fingernails and/or tying items around his neck"

Leadership Team Member / RBT

Date Reviewed

BCBA

Date Reviewed