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Functional Assessment Interview

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

Person Responding: _____ Date Completed: _____

Insurance: _____ Ins. Id #: _____

Phone: _____ Address: _____

Who currently lives in the home?:

_____

History of Services:

Date of Diagnosis: _____ Date of Referral: _____

Original Date of Date of diagnosis (if he/she has previously been diagnosed): _____

Diagnosed by whom: _____ Referred for ABA by whom:_____

Has your child received ABA in the past: No: ☐ Yes: ☐

If yes, dates of services: _____

If yes, previous provider: _____

If yes, approximate hours of service weekly: _____

Does your child (or did they in the past) receive other ancillary services:

Speech: _____

OT: : _____

PT: : _____

Current schedule: _____ Past Schedule: _____

Educational placement: _____

School District: _____

Grade: _____

Does your child have an IEP?: Yes: ☐ No: ☐

If yes, please include your most recent IEP when submitting your documentation

Does the family present with any spiritual or cultural preferences that may impact ABA services (e.g. observe the sabbath, observe any other religious holidays, go to church during the week, etc.)

No: ☐ Yes: ☐

If yes, please explain :_____

Does your child have any other (comorbid) diagnoses that may impact behavior?

No: ☐ Yes: ☐

If yes, please explain:

_____

_____

Does your child have any allergies or dietary restrictions: No ☐ Yes ☐ If yes, please explain :

_____

_____

Is your child taking any medications? No: ☐ Yes: x (please list below) No

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What are your child's sleeping habits?

Describe your child's daily schedule:

Monday – Friday	Weekends

Goals of Intervention: What goals would you like to achieve for your child and family?

_____

_____

How does your family do in the community: (restaurants, grocery or other stores, family outings, church, etc.)

_____

_____

Where would you like your child/family to be able to go that you now avoid?

_____

_____

Social Skills:

How does your child do in social settings? How does he/she interact with others?

_____

_____

Does your child have friends?

_____

_____

_____

Does your child play with toys? If so, describe their play skills:

_____

_____

_____

Child's Strengths:

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

_____

_____

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

_____

_____

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				

Receptive Communication: Is your child able to understand directions/ spoken language ?

Requests or instructions followed: No

_____

_____

_____

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

Self-care (e.g., dressing, toileting, bathing): Mom is needed for all self care tasks, sometimes yelling and uncooperative with self care tasks

Toileting: _____

Bathing: _____

Toothbrushing:_____

Handwashing:_____

Other: _____

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

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

Eating habits (e.g., self-feeding, utensil use, food variety): _____

_____

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

Requests or instructions followed: None

Behaviors imitated: _____

Problem Behaviors:

What are your concerns about your child's behavior? _____

_____

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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, substance abuse, sexual behavior)? Estimate how often, long, and severe.

Behavior	Description (insert behavior below)	Frequency	Duration	Severity
1.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	30 seconds ___ minutes ___ hours (occasionally)	☐ high ☐ medium ☐ low
2.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low
3.		☐ hourly ___ ☐ daily ___ ☐ weekly ___	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low

		☐ other:		
4.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low
5.		☐ hourly ___ ☐ daily ___ ☐ weekly ___ ☐ other:	___ seconds ___ minutes ___ hours	☐ high ☐ medium ☐ low

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

Do the behaviors occur most likely when:

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				

Transitions				
Other situations that are particularly difficult:				

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
_____	_____
_____	_____
_____	_____

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, or other providers have attempted in order to address your child's behavior, when they were used, and their impact (i.e., how they worked).

Intervention Attempted	Impact on Behavior

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 ☐ (Reason provided)

How does your child do with changes in routine(s)?

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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Schedule and availability:

Where are you looking for services? In our clinic, in school, at home?

_____

What is the family's preferred schedule and availability? Please note that we do our best to accommodate preferred schedules, consistent service may only be available at certain times.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Additional comments:

_____

_____

_____

_____

_____

_____

_____

_____