**Behavior Screening Form**

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| Child Information |
| Today’s Date |  | Person making Referral |  |
| Child First, Middle, Last Name  |  |
| Child Age |  | Date of Birth |  | MRN  |  |
| Current Diagnosis of Autism | [ ]  Yes [ ]  No | Estimated Intellectual Ability  | **[ ]** Above Average | **[ ]** Average to Below Average  | **[ ]** Intellectual Delay  |

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| Communication |
| How would you best characterize the child’s communication skills? |
| [ ]  | Sign Language | [ ]  | Augmentative Device | [ ]  | Picture System |
| [ ]  | Makes sounds | [ ]  | Uses single words | [ ]  | Speaks in sentences |

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| **Problem Behavior** |
| **Which behaviors are problematic for the family and/or child:** |
| **[ ]** Hurts Others (e.g., hitting, scratching, pushing, kicking, biting, slapping) |
| **[ ]** Destructive Behaviors (e.g., breaking/throwing items; kicking furniture/walls; slamming doors) |
| **[ ]** Tantrums (e.g., crying, screaming, yelling, falling to the floor) |
| **[ ]** Inappropriate language (e.g., swearing, saying hurtful things, threatening/teasing others, calling names) |
| **[ ]** Noncompliance (doesn’t follow directions) |
| **Are any of the below behaviors of concern:** (check all that apply) |
| **[ ]** Hurts Self (self-injurious behavior) | **[ ]** Runs away in the community | **[ ]** Covert behaviors (stealing/lying) |
| **[ ]** Inappropriate Sexual Behaviors | **[ ]** Plays with feces | **[ ]** Eats non-food items (Pica) |
| **Has anyone (including the child) gotten hurt as a result of these behaviors?** (e.g., breaking skin, bruising, swelling, broken bones)  | [ ]  Yes [ ]  No |
| **Behaviors of Concern Occur in Which of the Following Settings: (check all that apply)** |
| [ ]  | In the Home | [ ]  | At School | [ ]  | Out in the Community |
|  |
| Other Services Wanted: | [ ]  | Psychiatric Medication Consultation | [ ]  | Speech  |

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| **Other Concerns of Note/Helpful Information to Inform the Referral? (Continue on back)** |
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 **Thank you for taking the time to complete this information!**