Name: _____

Behavioral Consultation Services

OF NORTHERN ARIZONA

**INITIAL SCREENING FORM**

**INSTRUCTIONS**

Complete and return (in person or by fax) or bring with you:
Behavioral Consultation Services of Northern Arizona (BCSNA) LLC
906 W. University Ave. Suite #120
Flagstaff, Arizona 86001
Phone: 923-522-3780 Fax: 928-774-4277

For the most complete evaluation, please provide these additional items:
1. The individual's most recent physical or medical evaluation or medical record.
2. A copy of the most up to date immunization history
3. The most recent educational and psychological evaluations, including copies of a current IEP
4. All programs (previous and current) designed to treat the individual's target behaviors
5. The individual's typical daily schedule.

After receiving this information and a thorough review, you will be contacted to set up an initial evaluation appointment. If you have any questions or need assistance, please contact me at (928) 556-9935 or write to the above address. Thank you.

Date completed: _____ Completed by: _____

Referred By: _____

Address: _____

Telephone: _____

Name: _____

**PART I BIOGRAPHICAL INFORMATION**

1. Name: _____ 2. Date of Birth: _____

3. Individual currently lives at (circle one): Home Residential Facility Other: _____

Address of Residential Facility or Group Home: _____

Contact Person at Group Home & Phone: _____

4. Parents' Name: _____

Mother's Maiden Name: _____

Address: _____

County: _____ Telephone: _____

5. School or Institution: _____

Address: _____

Telephone: _____ Teacher or Therapist: _____

Type of school placement: _____ Number of teachers & aides in the classroom: __

Number of students: _____ Does the individual have a 1:1 aide? Yes No

6. Has the individual been seen before at BCSNA? Yes No

7. If child is over 18 years of age, who has legal custody / who is legal guardian?
(circle one)

Child Parent Other Not Assigned Yet

8. Please list the appropriate contact person, if not already listed above. Is this an emergency number?
Yes No

Name: _____ Telephone Number: _____

Address: _____

9. Does the referred individual have medical insurance? Yes No

If yes, what type? _____

Policy # and holder: _____

Group #: _____ Type: _____

If no, how would hospitalization be covered? _____

_____

10. a. Name of Primary Care Physician: _____

Address: _____

Name: _____

Telephone: _____

b. Name of other physician: _____

Address: _____

Telephone: _____

**PART II PSYCHOSOCIAL BACKGROUND**

1. Parents Age Education Occupation Martial Status

Father _____

Mother _____

Guardian _____

2. Who lives in the individual's residence?

| Name | Age | Gender | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

3. Who else living out of the residence are considered significant relationships to the individual?

| Name | Age | Gender | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

4. Please list community agencies/contacts who provide services to your child/family:

| Agency | Contact/Telephone | Nature of Service |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

5. Does the individual receive sources of public funding? Yes No

Which one (s)? Ex. SSI, DDA

Name: _____

_____

_____

_____

**PART III MEDICAL**

1. All previous Medical and Developmental Problems / Diagnoses:

_____

2. Height: _____ 3. Weight: _____

4. Current medical problems: _____

_____

5. Does the individual have any allergies to medicine, food or animals: _____

_____

6. Current medical equipment used (i.e. feeding pump, wheelchair, walker, etc.) _____

_____

7. Current medical treatments (i.e. dialysis, tube feeding, tracheotomy): _____

8. Current medications and dosages:

| Name | Frequency | Dose | Start Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

9. What other medications have been used:

_____

_____

Name: _____

**PART VI PAST MEDICAL HISTORY**

BIRTH

During Pregnancy: Mother's Age _____ Father's Age _____

Length of Pregnancy _____

Problems during Pregnancy:

Labor & Delivery Birth Hospital _____

Labor_____ Delivery (vaginal) or (c-section)

Apgar Scores _____ Weight _____

Problems in Delivery Room _____

Problems in NICU / Nursery _____

Additional Medical History:

| Hospitalizations (list) | Reason | Month/Year | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Surgeries (list)

_____

_____

_____

_____

Previous Medical tests and evaluations:

EEG

MRI or CT Scan

Chromosomes

Metabolic studies

Vision

Hearing

Feeding/swallowing

Gastrointestinal

Name: _____

Other

All Current Nutritional Supplements: Highest Daily Dose Results (positive or negative)

1. _____
2. _____
3. _____
4. _____

**PART V PROBLEM BEHAVIORS**

1. Record each problem behavior the individual displays and describe it specifically. Include any damage resulting from the problem behavior either to the individual or others. Please rank in order of concern to yourself or other caretakers.

| | Behavior | Description |
|---|---|---|
| a. | _____ | _____ |
| b. | _____ | _____ |
| c. | _____ | _____ |
| d. | _____ | _____ |
| e. | _____ | _____ |
| f. | _____ | _____ |
| g. | _____ | _____ |

2. Estimate the severity of the problem behavior of greatest concern (circle one).
   Moderate Severe Life-threatening
3. Has the individual ever been sent to the hospital to treat an injury resulting from the behavior?
   Yes No Describe: _____
   _____
4. Has the individual ever sent someone else to the hospital to treat an injury resulting from the behavior? Yes No Describe: _____
   _____
5. Has the individual ever been hospitalized to develop a treatment for these behavior problems?
   Yes No Describe: _____
   _____

Name: _____

6. In what settings do these behaviors occur?

   a. Home

   b. School

   c. Community: specify_____

   d. Other:_____

7. Estimate the current frequency of the problem behavior(s) (circle one).

   a. Less than one episode per week (list frequency)

   b. 1 to 3 episodes per week.

   c. Occurs about once daily.

   d. Occurs several times per day.

   e. Occurs every hour while awake.

8. How long has the individual been engaging in the problem behavior(s) (circle one)?

   a. Within past 6 months.

   b. More than 6 months but less than 1 year.

   c. More than 1 year but less than 3 years.

   d. More than 3 years but less than 5 years.

   e. More than 5 years but less than 10 years.

   f. More than 10 years.

9. When is the problem behavior(s) likely to occur (circle all that apply)

   a. When individual is left alone or unattended.

   b. When lots of people are around.

   c. When demands are placed on the individual.

   d. Mealtimes, dressing or bathing (circle).

   e. Time of day:

   g. Other:

10. Are there any occasions when the problem behavior(s) rarely or never occurs?

    _____

    _____

    _____

Name: _____

11. a. How do people (staff, parents, etc.) typically respond when the individual engages in the problem behavior(s)? (If a formal program is currently being conducted, refer to it here and send a copy. _____

_____

_____

b. How long has the program been in place? _____

12. Estimate the general trend of the problem behavior(s) during the past year (circle one).
a. Increasing (behavior getting worse).
b. Decreasing (behavior getting better).
c. Stable (about the same).

13. Does the individual display aggressive behavior toward staff or peers? If yes, explain:

_____

_____

_____

14. Was the onset of the problem behavior(s) associated with any specific event or series of events?

_____

_____

_____

15. Have the following procedures ever been used to treat the problem behavior(s) (circle all that have been used)?
a. Behavior Medications:
Name: _____
Dosage: _____
Start Date: _____ Still used? Yes/No Stop Date: _____
Estimated degree of success:

_____

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

Name: _____

b. Restraint.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

c. Protective Equipment.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

_____

d. Behavior Modification - positive reinforcement.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

Name: _____

Which problem behavior(s) was the treatment indicated for?

_____

_____

e. Behavior Modification - punishment.

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

f. Other

Describe: _____

_____

Start Date: _____ Still used? Yes/No Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

**PART VI ADAPTIVE BEHAVIOR**

1. Estimated level of functioning (circle one)

   Normal intelligence Mild MR Moderate MR Severe MR Profound MR

2. Circle each of the following that apply

   a. Ambulatory. g. Uses sign language to communicate.

   b. Feeds self. h. Uses pictures to communicate.

Name: _____

c. Toilet trained.
d. Can imitate a model.
e. Follows instructions
g. Uses words to communicate.
i. Uses assistive technology device to communicate.
j. Hearing impaired.
k. Visually impaired.

**PART VII MOTIVATION**

1. Does the individual appear to enjoy social interaction? Yes/No
   Please specify: _____

2. Please list:
   a. Favorite foods: _____
   b. Favorite recreational materials: _____
   d. Favorite activities: _____

**PART VIII OTHER INFORMATION**

1. What type of supervision does the individual require (circle one)?
   a. Can be left unattended for brief periods.
   b. Needs continuous monitoring, but can be accomplished in a group.
   c. Requires 1:1 supervision.

2. a. Does the individual have problems going to sleep at night? Yes/No.
   If yes, explain: _____
   _____
   _____

   b.Does the individual sleep through the night? Yes/No
   time to bed time _____ to wake _____

   c.Does the individual have any special needs overnight? Yes/No.
   If yes, explain: _____
   _____
   _____

Name: _____

3. If a program is developed and found to be effective in reducing your child's/individual's problem behavior, describe the resources you have available to maintain this program.

_____

_____

_____

_____

_____