

Home Observation Card Side 1

Child's Name: _____ Date/Time: _____

Activity: _____ Observer: _____

Describe Challenging Behavior:

What Happened Before?

<input type="checkbox"/> Told or asked to do something	<input type="checkbox"/> Playing alone	<input type="checkbox"/> Changed or ended activity
<input type="checkbox"/> Removed an object	<input type="checkbox"/> Moved activity/location to another	<input type="checkbox"/> Object out of reach
<input type="checkbox"/> Not a preferred activity	<input type="checkbox"/> Told "No", "Don't", "Stop"	<input type="checkbox"/> Child requested something
<input type="checkbox"/> Difficult task/activity	<input type="checkbox"/> Attention given to others	<input type="checkbox"/> Other (specify) _____

What Happened After?

<input type="checkbox"/> Given social attention	<input type="checkbox"/> Punished or Scolded	<input type="checkbox"/> Put in "time-out"
<input type="checkbox"/> Given an object/activity/food	<input type="checkbox"/> Request or demand withdrawn	<input type="checkbox"/> Ignored
<input type="checkbox"/> Removed from activity/area	<input type="checkbox"/> Request or demand delayed	<input type="checkbox"/> Given assistance/help
<input type="checkbox"/> Other (specify) _____		

Purpose of Behavior:

To Get or Obtain:		To Get Out Of or Avoid:	
<input type="checkbox"/> Activity	<input type="checkbox"/> Attention	<input type="checkbox"/> Activity	<input type="checkbox"/> Attention <input type="checkbox"/> Transition
<input type="checkbox"/> Object	<input type="checkbox"/> Food	<input type="checkbox"/> Object	<input type="checkbox"/> Food
<input type="checkbox"/> Person	<input type="checkbox"/> Place	<input type="checkbox"/> Person	<input type="checkbox"/> Place
<input type="checkbox"/> Help	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Demand/Request	<input type="checkbox"/> Other (specify) _____

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Home Observation Card

Side 2

Setting Events/Lifestyle Influences:

- Hunger
- Uncomfortable clothing
- Absence of fun activities, toys
- Too hot or too cold
- Absence of a person
- Loud noise
- Sick
- Lack of sleep
- Unexpected loss or change in activity/object
- Medication side effects
- Extreme change in routine
- Other (specify) _____

List Notes/Comments/Unusual Events:

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