

ABC Data Sheet

Child name: _____

Person filling out this form: _____

Date	Time	Type of behavior Pick 1 MAIN concern	Intensity	Trigger (what happened right before the behavior?) Mark ALL that apply	Outcome (what happened after the behavior?) Mark ALL that apply
<div style="background-color: #444; color: white; padding: 5px; display: inline-block;">Example</div> 10/25	1:25	<input type="checkbox"/> Aggression <input checked="" type="checkbox"/> Refusing to do... <input type="checkbox"/> Blurting out <input type="checkbox"/> Leaving area <input type="checkbox"/> Repetitive bhvr. <input type="checkbox"/> Tantrum <input type="checkbox"/> Other: _____	5 – very intense 4 – intense 3 – moderate <input checked="" type="checkbox"/> 2 – mild 1 – very mild	<input type="checkbox"/> a. uninterested in activity <input checked="" type="checkbox"/> b. activity is aversive <input type="checkbox"/> c. bored w/ activity <input type="checkbox"/> d. cleaning up <input type="checkbox"/> e. physical prompt <input type="checkbox"/> f. verbal correction <input type="checkbox"/> g. circle time <input type="checkbox"/> h. remove preferred item Other (what triggers this behavior?) _____ _____ _____	<input type="checkbox"/> a. get adult to look or talk to them <input type="checkbox"/> b. get peer to look or talk to them <input type="checkbox"/> c. get preferred activity (eventually) <input type="checkbox"/> d. get object/things (eventually) <input type="checkbox"/> e. get sensation (touch, taste, sound, sight, smell) <input type="checkbox"/> f. get other, describe _____ <input type="checkbox"/> g. avoid adult attention <input type="checkbox"/> h. avoid peer attention <input checked="" type="checkbox"/> i. avoid undesired activity/task <input type="checkbox"/> j. avoid sensation (touch, taste, sound, sight, smell) <input type="checkbox"/> k. avoid/escape other, describe _____
<p><u>Any known setting events today???</u> <input type="checkbox"/> hunger <input type="checkbox"/> conflict at home <input type="checkbox"/> conflict with peers at school <input type="checkbox"/> medication <input type="checkbox"/> illness <input type="checkbox"/> recent disappointment <input type="checkbox"/> lost privilege <input type="checkbox"/> lack of sleep <input checked="" type="checkbox"/> change in routine <input type="checkbox"/> Other: _____</p>					
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