

Behavior Incident Report

Program ID: _____

Child Name:		Referring Staff:	
Classroom ID:	Child ID:	Date	Time:
Behavior Description:			
Problem Behavior (check most intrusive)			
<input type="checkbox"/> Physical aggression	<input type="checkbox"/> Non-compliance	<input type="checkbox"/> Repetitive behaviors	
<input type="checkbox"/> Disruption/Tantrums	<input type="checkbox"/> Social withdrawal/Isolation	<input type="checkbox"/> Hurting self	
<input type="checkbox"/> Inconsolable crying	<input type="checkbox"/> Running away	<input type="checkbox"/> Trouble falling asleep	
<input type="checkbox"/> Verbal aggression	<input type="checkbox"/> Breaking/Destroying objects or items	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Inappropriate language	<input type="checkbox"/> Unsafe behaviors		
Activity (check one)			
<input type="checkbox"/> Arrival	<input type="checkbox"/> Outdoor play	<input type="checkbox"/> Departure	
<input type="checkbox"/> Circle/Large group activity	<input type="checkbox"/> Special activity	<input type="checkbox"/> Therapy	
<input type="checkbox"/> Small group activity	<input type="checkbox"/> Field trip	<input type="checkbox"/> Quiet time/Nap	
<input type="checkbox"/> Centers/Indoor play	<input type="checkbox"/> Self-care/Bathroom	<input type="checkbox"/> Transportation	
<input type="checkbox"/> Diapering	<input type="checkbox"/> Transition	<input type="checkbox"/> Individual activity	
<input type="checkbox"/> Meals	<input type="checkbox"/> Clean-up	<input type="checkbox"/> Other: _____	
Others Involved (check one)			
<input type="checkbox"/> Teacher	<input type="checkbox"/> Family Member	<input type="checkbox"/> Transportation driver	
<input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Support/Administrative staff	<input type="checkbox"/> Kitchen staff	
<input type="checkbox"/> Peers	<input type="checkbox"/> Substitute	<input type="checkbox"/> None	
<input type="checkbox"/> Therapist	<input type="checkbox"/> Classroom volunteer	<input type="checkbox"/> Other: _____	
Possible Motivation (check one)			
<input type="checkbox"/> Obtain desired item	<input type="checkbox"/> Gain adult attention/comfort	<input type="checkbox"/> Avoid sensory	
<input type="checkbox"/> Obtain desired activity	<input type="checkbox"/> Avoid adults	<input type="checkbox"/> Don't know	
<input type="checkbox"/> Gain peer attention	<input type="checkbox"/> Avoid task	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Avoid peers	<input type="checkbox"/> Obtain sensory		
Response (check one or the most intrusive)			
<input type="checkbox"/> Verbal reminder	<input type="checkbox"/> Provide physical comfort	<input type="checkbox"/> Teacher contact family	
<input type="checkbox"/> Redirect to different activity/toy	<input type="checkbox"/> Curriculum modification	<input type="checkbox"/> Time out	
<input type="checkbox"/> Move within group	<input type="checkbox"/> Re-teach/Practice expected behavior	<input type="checkbox"/> Physical guidance	
<input type="checkbox"/> Remove from activity	<input type="checkbox"/> Loss of activity	<input type="checkbox"/> Physical hold/Restrain	
<input type="checkbox"/> Remove from area	<input type="checkbox"/> Time with a teacher	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Remove item	<input type="checkbox"/> Time in a different classroom or adult outside of classroom		
Administrative Follow-Up (check one or most intrusive)			
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Targeted group intervention	<input type="checkbox"/> Conditional enrollment	
<input type="checkbox"/> Talk with child	<input type="checkbox"/> Temporary removal from classroom	<input type="checkbox"/> Transfer to another program	
<input type="checkbox"/> Contact family	<input type="checkbox"/> Sent home for remainder of day	<input type="checkbox"/> Reduce hours in program	
<input type="checkbox"/> Family meeting	<input type="checkbox"/> Sent home for 1 or more days	<input type="checkbox"/> Dismissal from program	
<input type="checkbox"/> Arrange behavioral consultation/team		<input type="checkbox"/> Other: _____	
Comments:			
<i>If this is the <u>first BIR</u> for the child, please select the following demographic information:</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> IEP in place <input type="checkbox"/> No IEP <input type="checkbox"/> Dual language	Select all that apply: _____ American Indian or Alaskan Native _____ Asian _____ Black or African American _____ Hispanic/Latino _____ Native Hawaiian or Other Pacific Islander _____ White