Behavioral/Emotional Concerns—Caregiver Checklist

for Adults with Intellectual and other Developmental Disabilities (IDD)

Last/First Name: _____

Address: _____

_____

Phone: _____ DOB ___/___/___ Gender: ____
dd mm yyyy

Medical Record Number: _____

PART B: CAREGIVER SECTION (Caregiver to fill out or provide information)

What type of developmental disability does the patient have (i.e., what caused it?) (e.g., Down syndrome, Fragile X syndrome) _____

☐ Unsure/don't know

What is the patient's level of functioning?

☐ Borderline ☐ Mild

☐ Moderate ☐ Severe

☐ Profound ☐ Unknown

BEHAVIORAL PROBLEM

When did the behavioral problem start? ___/___/___

When was patient last "at his/her best"? (i.e., before these behavior problems) ___/___/___

Description of current difficult behavior(s):

_____

Has this sort of behavior happened before?

_____

What triggers the behavior?

_____

And what do you (or other caregivers) do when the behavior occurs?

_____

What, in the past, helped or did not help to manage the behavior? (include medications or trials of medications to manage behavior[s])

_____

What is being done now to try to help the patient and manage his/her behaviors? How is it working?

_____

Risk?

☐ To self

☐ To others

☐ To environment

☐ Aggression to others

☐ Self-injurious behavior

Severity of Damage or Injury

☐ Mild (no damage)

☐ Moderate (some)

☐ Severe (extensive)

Frequency of Distressing (Challenging) Behavior

☐ More than once daily

☐ Daily

☐ Weekly

☐ Monthly

PART B: CAREGIVER SECTION

Name: _____ DOB ___ / ___ / ___

Please check (√) if there has been any recent deterioration or change in:

- ☐ Mood
- ☐ Bowel/bladder continence
- ☐ Appetite
- ☐ Sleep
- ☐ Social involvement
- ☐ Communication
- ☐ Interest (in leisure activities or work)
- ☐ Seizure frequency
- ☐ Self care (e.g., eating, toileting, dressing, hygiene)
- ☐ Independence
- ☐ Initiative
- ☐ Cognition (e.g., thinking, memory)
- ☐ Movement (standing, walking, coordination)
- ☐ Need for change in supervision and/or placement

When did this change/deterioration start?

Caregiver comments:

1. POSSIBLE PHYSICAL HEALTH PROBLEMS OR PAIN

Are you or other caregivers aware of any **physical health or medical problems** that might be contributing to the patient's behavior problems?

☐No ☐Yes

If yes, please specify or describe:

Could pain, injury or discomfort be contributing to the behavior change?

☐ No ☐ Yes ☐ Possibly

Specify:

Would you know if this patient was in pain?

☐No ☐Yes

How does this patient communicate pain?

☐Expresses verbally

☐Points to place on body

☐Expresses through non-specific behavior disturbance (describe):

☐ Other (specify):

Are there any concerns about medications or possible medication side effects?

PART B: CAREGIVER SECTION

Name: _____ DOB ___ / ___ / ___

2.1: CHANGES IN ENVIRONMENT *before* problem behavior(s) began

Have there been any recent changes or stressful circumstances regarding:

☐ **Caregivers?** (family members, paid staff, volunteers)

☐ **Care provision?** (e.g., new program or delivered differently, fewer staff to support)

☐ **Living environment?** (e.g., co-residents)

☐ **School or day program or work?**

2.2: SUPPORT ISSUES

Are there any problems in this patient's support system that may contribute to his/her basic needs not being met?

Does this patient have a ☐ **hearing** or ☐ **vision problem?**

☐ No ☐ Yes

If yes, what is in place to help him/her?

_____

Does this patient have a **communication problem?**

☐ No ☐ Yes

If yes, what is in place to help him/her?

_____

Does environment seem **too physically demanding** for this patient?

☐ No ☐ Yes

Does this patient have **mobility problems** or **physical restrictions?**

☐ No ☐ Yes

If yes, what is in place to help him/her?

_____

If yes, does he/she receive physical therapy?

☐ No ☐ Yes

Does this patient have a problem with **sensory triggers?**

☐ No ☐ Yes

If yes, what is in place to help him/her?

_____

If yes, do you think this patient's environment is

☐ over-stimulating?

☐ under-stimulating? or

☐ just right for this patient?

Does this patient have enough opportunities for **appropriate physical activities?**

☐ No ☐ Yes

Are there **any supports or programs that might help this patient** and that are not now in place**?**

☐ No ☐ Yes

If yes, please describe:

_____

Caregiver comments:

_____

PART B: CAREGIVER SECTION

Name: _____ DOB ___ / ___ / ___

3: EMOTIONAL ISSUES Please check (√) if any of these factors may be affecting this patient:

Any recent change in relationships with significant others (e.g., staff, family, friends, romantic partner)

- ☐ **Additions** (e.g., new roommate, birth of sibling)
- ☐ **Losses** (e.g., staff change, housemate change)
- ☐ **Separations** (e.g., decreased visits by volunteers, sibling moved out)
- ☐ **Deaths** (e.g., parent, housemate, caregiver)

Issues of assault or abuse

	Past	Ongoing	Date(s)
Physical	☐	☐	_____
Sexual	☐	☐	_____
Emotional	☐	☐	_____
Exploitation	☐	☐	_____

Comments: _____

- ☐ **Teasing or bullying**
- ☐ **Being left out of an activity or group**
- ☐ **Anxiety about completing tasks**
- ☐ **Stress or upsetting event, at school or work**
- ☐ **Issues regarding sexuality and relationships**
- ☐ **Inability to verbalize feelings**
- ☐ **Disappointment(s)**
  (e.g., being surpassed by siblings; not being able to meet goals, such as driving or having a romantic relationship)
- ☐ **Growing insight into disabilities and impact on own life**
  (e.g., that he/she will never have children, sibling has boy/girlfriend)
- ☐ **Life transitions** (e.g., moving out of family home, leaving school, puberty)
- ☐ **Other triggers** (e.g., anniversaries, holidays, environmental, associated with past trauma)

Specify: _____

Caregiver comments:

_____

Has this patient ever been diagnosed with a psychiatric disorder? ☐ No ☐ Unsure

☐ Yes: _____

Has this patient ever been hospitalized for a psychiatric reason? ☐ No ☐ Unsure

☐ Yes: _____

PART B: CAREGIVER SECTION

Name: _____ DOB ___ / ___ / ___

CAREGIVER CONCERNS AND INFORMATION NEEDS

Do you, and other caregivers, have the information you need to help this patient, in terms of:

- The type of developmental disability the patient has and possible causes of it? ☐ Yes ☐ No ☐ Unsure
- What the patient's abilities, support needs, and potential are? ☐ Yes ☐ No ☐ Unsure
- Possible physical health problems with this kind of disability? ☐ Yes ☐ No ☐ Unsure
- Possible mental health problems and support needs with this kind of disability (e.g., anxiety more common with Fragile X syndrome)? ☐ Yes ☐ No ☐ Unsure
- How to help if the patient has behavior problems/emotional issues? ☐ Yes ☐ No ☐ Unsure
- Recent changes or deterioration in the patient's abilities? ☐ Yes ☐ No ☐ Unsure

Are there any issues of **caregiver stress** or potential burnout? ☐ Yes ☐ No ☐ Unsure

Caregiver comments:

Caregiver's additional general comments or concerns:

Thank you for the information you have provided. It will be helpful in understanding this patient better and planning and providing health care for him or her.