Behavior Assessment System for Children, Third Edition (BASC™-3)
BASC-3 Parent Rating Scales - Child
Interpretive Summary Report with Intervention Recommendations
_Cecil R. Reynolds, PhD, & Randy W. Kamphaus, PhD_

<table>
<thead>
<tr>
<th><strong>Child Information</strong></th>
<th><strong>Test Information</strong></th>
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<tr>
<td>ID: 12345</td>
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<tr>
<td>Name: Sample Examinee</td>
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Norm Group 1: General Combined
COMMENTS AND CONCERNS

No comments or concerns were provided.
VALIDITY INDEX SUMMARY

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CLINICAL AND ADAPTIVE T-SCORE PROFILE

T Score

Hyperactivity  Aggression  Conduct Problems  Externalizing Problems  Anxiety  Depression  Somatization  Internalizing Problems  Attention Problems  Atypicality  Withdrewal  Behavioral Symptoms Index  Adaptability  Social Skills  Leadership  Functional Communications  ADL  Adaptive Skills

General Combined 80 47 40 57 52 73 44 58 65 41 55 64 47 46 33 53 55 46

Percentile

General Combined 99 48 8 80 66 97 33 81 91 13 78 90 38 32 6 58 65 34
## CLINICAL AND ADAPTIVE SCORE TABLE: General Combined Norm Group

### Composite Score Summary

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<th>Raw Score</th>
<th>T Score</th>
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### Composite Comparisons

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Mean $T$ score of the BSI

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<th>Mean $T$ score of the Adaptive Skills Composite</th>
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### Scale Score Summary

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Note: All classifications of test scores are subject to the application of the standard error of measurement (SEM) when making classification decisions. Individual clinicians are advised to consider all case-related information to determine if a particular classification is appropriate. See the BASC-3 Manual for additional information on SEMs and confidence intervals.
VALIDITY INDEX NARRATIVES

The BASC-3 F Index is a classically derived infrequency scale, designed to assess the possibility that a rater has depicted a child's behavior in an inordinately negative fashion. The F Index consists of items that represent maladaptive behaviors to which the rater answered "almost always" and adaptive behaviors to which the rater responded "never."

The F Index score produced from the ratings of Sample by Anne falls within the Acceptable range and does not indicate the presence of negative response distortion.

The Consistency Index identifies situations when the rater has given inconsistent responses to items that are typically answered in a similar way, based on comparisons made to raters from the general population. The Consistency Index was designed to identify ratings that might not be easily interpretable due to these response discrepancies.

The Consistency Index score produced from the ratings of Sample by Anne falls within the Acceptable range and indicates the rater consistently answered items when completing the rating form.
VALIDITY INDEX ITEM LISTS

Validity Index ratings for F Index, D Index, Response Pattern Index, and Consistency Index are all Acceptable.

F Index
The F Index rating is Acceptable.

Response Pattern Index
The Response Pattern Index rating is Acceptable.

Consistency Index
The Consistency Index rating is Acceptable.
CLINICAL AND ADAPTIVE SCALE NARRATIVES

This report is based on Anne Sample's rating of Sample's behavior using the BASC-3 Parent Rating Scales form. The narrative and scale classifications in this report are based on T scores obtained using norms. Scale scores in the Clinically Significant range suggest a high level of maladjustment. Scores in the At-Risk range may identify a significant problem that may not be severe enough to require formal treatment or may identify the potential of developing a problem that needs careful monitoring.

Externalizing Problems
The Externalizing Problems composite scale T score is 57, with a 90% confidence interval range of 53-61 and a percentile rank of 80.

Sample's T score on Hyperactivity is 80 and has a percentile rank of 99. This T score falls in the Clinically Significant classification range and usually warrants follow-up. Sample's mother reports that Sample engages in many disruptive, impulsive, and uncontrolled behaviors.

Sample's T score on Aggression is 47 and has a percentile rank of 48. Sample's mother reports that Sample tends not to act aggressively any more often than others of her age.

Sample's T score on Conduct Problems is 40 and has a percentile rank of 8. Sample's mother reports that Sample demonstrates rule-breaking behavior no more often than others her age.

Internalizing Problems
The Internalizing Problems composite scale T score is 58, with a 90% confidence interval range of 54-62 and a percentile rank of 81.

Sample's T score on Anxiety is 52 and has a percentile rank of 66. Sample's mother reports that Sample displays anxiety-based behaviors no more often than others her age.

Sample's T score on Depression is 73 and has a percentile rank of 97. This T score falls in the Clinically Significant classification range and follow-up may be necessary. Sample’s mother reports that Sample is withdrawn, pessimistic, and/or sad. Scores in this range usually warrant assessment of vegetative symptoms (e.g., weight loss or gain, fatigue). Suicidal tendencies should also be explored.

Sample's T score on Somatization is 44 and has a percentile rank of 33. Sample's mother reports that Sample complains of health-related problems to about the same degree as others her age.

Behavioral Symptoms Index
The Behavioral Symptoms Index (BSI) composite scale T score is 64, with a 90% confidence interval range of 60-68 and a percentile rank of 90. Sample's T score on this composite scale falls in the At-Risk classification range. Scale summary information for Hyperactivity, Aggression, and Depression (scales included in the BSI) has been provided above. Scale summary information for the remaining BSI scales is given next.

Sample's T score on Atypicality is 41 and has a percentile rank of 13. Sample's mother reports that Sample generally displays clear, logical thought patterns and she is generally aware of her surroundings.

Sample's T score on Withdrawal is 55 and has a percentile rank of 78. Sample's mother reports that Sample does not avoid social situations and appears to be capable of developing and maintaining friendships with others.

Sample's T score on Attention Problems is 65 and has a percentile rank of 91. This T score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample has difficulty maintaining necessary levels of attention at school. The problems experienced by Sample might disrupt academic performance and functioning in other areas.
Adaptive Skills
The Adaptive Skills composite scale T score is 46, with a 90% confidence interval range of 43-49 and a percentile rank of 34.

Sample’s T score on Adaptability is 47 and has a percentile rank of 38. Sample’s mother reports that Sample is able to adapt as well as most others her age to a variety of situations.

Sample’s T score on Social Skills is 46 and has a percentile rank of 32. Sample’s mother reports that Sample possesses sufficient social skills and generally does not experience debilitating or abnormal social difficulties.

Sample’s T score on Leadership is 33 and has a percentile rank of 6. This T score falls in the At-Risk classification range and follow-up may be necessary. Sample’s mother reports that Sample sometimes has difficulty making decisions, lacks creativity, and/or has trouble getting others to work together effectively.

Sample’s T score on Activities of Daily Living is 55 and has a percentile rank of 65. Sample’s mother reports that Sample is able to adequately perform simple daily tasks in a safe and efficient manner.

Sample’s T score on Functional Communication is 53 and has a percentile rank of 58. Sample’s mother reports that Sample generally exhibits adequate expressive and receptive communication skills and that Sample is usually able to seek out and find new information when needed.
BASC-3 PRS-C INTERVENTION RECOMMENDATIONS

Note. Information contained in the Intervention Summary section of this report is based on the BASC-3 Behavior Intervention Guide, authored by Kimberly J. Vannest, Cecil R. Reynolds, and Randy W. Kamphaus.

<table>
<thead>
<tr>
<th>Primary Improvement Areas</th>
<th>Secondary Improvement Areas</th>
<th>Adaptive Skill Strengths</th>
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</thead>
<tbody>
<tr>
<td>- Hyperactivity</td>
<td>- Leadership</td>
<td>- None</td>
</tr>
<tr>
<td>- Depression</td>
<td>- Attention Problems</td>
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</table>

Sample's scores on Hyperactivity and Depression fall in the clinically significant range and probably should be considered among the first behavioral issues to resolve. Her score on Attention Problems is also elevated and may warrant targeted interventions and/or further monitoring to ensure it doesn't worsen.

Note that Sample had a score on Leadership that is an area of concern. Interventions for this area are not provided in this report. However, this area may require additional follow up.

Sample's BASC-3 profile indicates significant problems with Hyperactivity, Depression, and Attention Problems. Based on Anne Sample's ratings, Sample is experiencing problems with the following behaviors:

Hyperactivity
- fiddling with things
- interrupting others
- disrupting others
- having poor self-control
- acting without thinking
- being overly active
- not waiting for turn

Depression
- getting easily upset
- changing moods quickly
- complaining about not being liked
- being sad
- being pessimistic
- being lonely

Attention Problems
- paying attention
- listening well
- staying focused

Primary Improvement Area: Hyperactivity

Hyperactivity problems are considered to be one of Sample's most significant behavioral and emotional areas to address. The *DSM-5™* lists symptoms such as fidgeting and squirming, leaving a seat unexpectedly, running or climbing inappropriately, failing to stay quiet, having difficulty waiting for a turn, or frequently interrupting and intruding socially. Hyperactivity problems can occur alone or can co-occur with attention problems and are usually exhibited by children in both home and school settings.
There are a variety of interventions that have been shown to reduce, or have shown promise for reducing, hyperactive behavior, including:

- Contingency Management
- Daily Behavior Report Cards (DBRC)
- Functional Behavioral Assessment
- Multimodal Interventions
- Parent Training
- Self-Management
- Task Modification

Detailed summaries of the Contingency Management and Self-Management intervention strategies are provided below. See the BASC-3 Behavior Intervention Guide for more information about these strategies and the other intervention strategies listed above.

**Hyperactivity Intervention Option 1: Contingency Management**

In contingency management for hyperactivity, behavioral interventions are used to modify consequent events that maintain hyperactive and impulsive behavior. Contingency management involves shaping the child's existing behavior and providing opportunities for the new, desired behavior to become internalized. Contingency management programs for hyperactivity include the individual or combined use of behavioral intervention strategies such as token economies; point systems; verbal praise; response cost; timeout from peers, reinforcers, attention, or privileges; varying amounts and frequency of teacher attention; verbal reprimands; and removal of praise. The goal of contingency management is to decrease the child's activity levels that negatively impact learning by reshaping the environment to reinforce or eliminate behaviors.

The essential elements of Contingency Management include the following:

1. Define the behavioral objectives clearly in operationally defined terms.
2. Identify pre-established and taught routines for earning and losing reinforcers.
3. Provide appropriate levels and types of reinforcers to shape behavior.
4. Deliver contingencies consistently at fixed or random intervals.
5. Implement response-cost contingencies as needed.

The procedural steps for incorporating contingency management strategies into the treatment of hyperactivity are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

**PREP**

- Select a behavior to target. There may be several that are problematic, but only choose one to start.
- Define the child's behavior in operational terms.
- Identify who will record baseline data on the frequency (i.e., how often) and/or severity (i.e., how much) of the hyperactivity. Use this information as a sample of functioning (e.g., length of time child remains seated, amount of time child waits before blurting out an answer) before the intervention to permit evaluation of the degree of post-intervention improvement.
- Consider the child's preference for reinforcers. For example, if the child enjoys computer games, computer time can be earned or lost. Reinforcement surveys can help to determine reinforcers that are appropriate and meaningful to the child.

**IMPLEMENT**
Hyperactivity Intervention Option 2: Self-Management

Self-management strategies for hyperactivity are techniques that children can use to monitor their own activity level, record the results, and compare this level to a predetermined acceptable level of activity. Self-management in this context involves a combination of three behavioral techniques: self-monitoring, self-monitoring plus reinforcement, and self-reinforcement. The goal of self-management training is to increase the child's awareness of his or her own level of activity in order to produce an automatic response without relying on external reinforcement or prompting.

The essential elements of Self-Management Training include the following:

1. Teach the child to monitor his or her own activity level.
2. Teach the child to record his or her own activity level.
3. Teach the child to check against self-determined goals.
4. Teach the child to reinforce him- or herself.

The procedural steps for incorporating self-management strategies into the treatment of hyperactivity are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP
Primary Improvement Area: Depression

Depression-related symptoms and behaviors are considered one of Sample's most significant behavioral and emotional problems. The Depression scale on the BASC-3 rating scales indicates feelings of unhappiness, sadness, and stress that may result in an inability to carry out everyday activities. Depression is a condition resulting from a combination of distorted cognitions; a lack of positive reinforcement for rational cognitions and
behaviors; and an abundance of negative reinforcement for dysfunctional emotions, thinking, and behaviors. Cognitive theory attributes depression to negative or depression-producing thoughts or schemas. Negative events experienced by a person are linked to internal attributes, resulting in negative thinking that is used to interpret new events, which can ultimately lead to depression. Behavioral theory, on the other hand, considers depression to be a result of stressful events that lead to a disruption of adaptive behavior or stem from a lack of positive reinforcement and an excess of negative consequences.

There are two groups of intervention strategies that have been shown to effectively remediate problems associated with depression, including:

- Cognitive-Behavioral Therapy (which typically includes one or more of the strategies below)
  - Psychoeducation
  - Problem-Solving Skills Training
  - Cognitive Restructuring
  - Pleasant-Activity Planning
  - Relaxation Training
  - Self-Management Training
  - Family Involvement
- Interpersonal Psychotherapy

A detailed summary of Relaxation Training and Problem-Solving Skills Training intervention is provided below. See the BASC-3 Behavior Intervention Guide for additional details about these interventions, along with the other intervention strategies listed above.

**Depression Intervention Option 1: Relaxation Training**

Relaxation training teaches children to relax by monitoring muscle tension created by stressful situations and events. Tension-related physical discomfort can exacerbate common depressive symptoms and cause a child to feel even worse about him- or herself and the situation. Improvements in the child's physical well-being can influence his or her thoughts and emotions and lead to a reduction in depressive symptomatology.

The goal of relaxation training is to help the child learn to use physiological changes in his or her body to relieve depressive symptoms.

The essential elements of Relaxation Training include the following:
1. Identify emotional triggers and their corresponding physical symptoms.
2. Teach the child the selected relaxation techniques.

The procedural steps for incorporating Relaxation Training into the treatment of depression are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

**PREP**
- Identify a specific symptom of the child's depression, along with the effect it has on the child (e.g., crying, headaches).

**IMPLEMENT**
- Teach the child to use a relaxation technique.
- Ask the child to imagine a situation that causes the undesired symptoms.
Problem solving enables a child to identify negative thinking that occurs in a specific situation, recognize how those thoughts can lead to depression, and replace those thoughts and subsequent feelings with healthier ones.

The goal of problem-solving skills training is to help a child to view situational depression (caused by a lack of positive reinforcement) as a dilemma to be resolved rather than as a hopeless situation or an incurable disease.

The essential elements of Problem-Solving Training include the following:

1. Define the problem (e.g., thinking patterns, loss of appetite, decreased interest, agitation) as actionable.
2. Generate potential actions or solutions.
3. Evaluate these options.
4. Select the option that is the best fit and try it out.
5. Evaluate and revise as desired.

The procedural steps for incorporating problem-solving skills training into the treatment of depression are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

**PREP**

- Identify acceptable times and locations to meet privately with the child or the child and parent(s) as appropriate.
- Prepare to gather information from outside sources about the types of challenges and problems the child is facing if the child is not forthcoming or has limited self-awareness.

**IMPLEMENT**

- Discuss with the child the likely causes of his or her depression and the resulting symptoms.
- Reframe these in the context of problems to be solved rather than an illness to be treated.
- Brainstorm with the child to generate solutions to the problem.
  * For example, a child may begin to experience feelings of loneliness after quitting the swim team. Solutions to this problem might include rejoining the team or joining a similar or more interesting social group.
  * Divorce, death, and other incidents involving bereavement and loss of control require solutions that focus on the child's feelings, thoughts, or behaviors rather than the event itself. The event itself cannot be changed, but the feelings, thoughts, and behaviors that result from the event may be actionable.
- Together, evaluate the pros and cons of each solution and choose the best option to try.
- Be aware of and sensitive to the desires, strengths, and needs of the child during solution generation and selection. Start with simple solutions to avoid overwhelming the child.
- Work out a gradual approach with the child as you would for a homework assignment, outlining the steps needed and setting a target date for completion.
EVALUATE

- Monitor the child's progress. Consider revising the plan as necessary. Provide plenty of encouragement both for attempts and for successes.

Secondary Improvement Area: Attention Problems

Attention problems are considered to be one of Sample's most significant behavioral and emotional areas to address. Attention problems are defined as chronic and severe inconsistencies in the ability to maintain and regulate focus to tasks for more than short periods of time, and are characterized by distractibility, an inability to concentrate, an inability to maintain attention to tasks for long periods of time, disorganization, failure to complete tasks, and a lack of study skills. Children with attention problems exhibit an inability to control and direct attention to the demands of a task and are frequently distracted by internal distractions and irrelevant stimuli, even in a relatively quiet classroom environment.

The interventions presented below are behaviorally based, and involve strategies that include learning new behaviors and learning how to monitor existing behavior periodically. These interventions include:

- Classwide Peer Tutoring
- Computer-Assisted Instruction
- Contingency Management
- Daily Behavior Report Cards
- Modified-Task Presentation Strategies
- Multimodal Interventions
- Parent Training
- Self-Management

Detailed summaries of the Daily Behavior Report Cards and Modified Task-Presentation intervention strategies are provided below. See the BASC-3 Behavior Intervention Guide for more information about these strategies and the other intervention strategies listed above.

Attention Problems Intervention Option 1: Daily Behavior Report Cards

Daily behavior report cards (DBRCs) are used to record a child's behavior each day. The goal in implementing a DBRCs strategy is to change behavior by providing systematic feedback on performance and progress to children and parents, followed by appropriate reinforcement. The result is increased attention (or decreased inattention) during specific tasks and conditions.

The essential elements of DBRCs include the following:
1. Define the target behaviors.
2. Monitor and record behaviors daily.
3. Provide reinforcement for exhibiting the target behaviors.
4. Communicate results to children and parents.

The procedural steps for incorporating DBRCs into the treatment of attention problems are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.

PREP

- Identify the target behaviors for improving attention.
- Identify the rater of the target behavior.
Attention Problems Intervention Option 2: Modified Task-Presentation

Modified task-presentation strategies refer to a collection of specific options that can be used to increase the interest level of an activity, with the goal of increasing the amount of time the child attends to learning the task or activity. Based on information obtained through a functional behavioral assessment, tasks are altered using antecedent instructional modifications.

A number of modification strategies have been recommended by researchers, including:

1. Offering a choice of instructional activities
2. Providing guided notes and instruction in attending to relevant information
3. Using high-interest activities and hands-on demonstrations
4. Modifying in-class assignments and responses
5. Modifying homework
6. Highlighting relevant material or key information with colors, symbols, or font changes

The procedural steps for incorporating modified task-presentation strategies into the treatment of attention problems are summarized below. See the BASC-3 Behavior Intervention Guide for a detailed discussion of this topic.
When using any intervention, it is important to monitor the effectiveness of the interventions you are trying. For interventions that include the Social Skills scale you may choose to use the BASC-3 Progress Monitor Social Withdrawal forms. For interventions that include the Adaptability, Functional Communication, and Social Skills scales, you may choose to use the BASC-3 Progress Monitor Adaptive Skills form. Regardless of the method used to monitor progress, it is important to document the effectiveness of the interventions you have tried with Sample. The BASC-3 Behavior Intervention Guide Documentation Checklist is designed to facilitate the recording of the steps that have been taken to remediate or manage a child's behavioral or emotional problem(s). It also includes a section to record the fidelity of the intervention approach that has been used, a factor that is critical to the success of any intervention program.

**Concluding Recommendations**

When using any intervention, it is important to monitor the effectiveness of the interventions you are trying. For interventions that include the Social Skills scale you may choose to use the BASC-3 Progress Monitor Social Withdrawal forms. For interventions that include the Adaptability, Functional Communication, and Social Skills scales, you may choose to use the BASC-3 Progress Monitor Adaptive Skills form.

Regardless of the method used to monitor progress, it is important to document the effectiveness of the interventions you have tried with Sample. The BASC-3 Behavior Intervention Guide Documentation Checklist is designed to facilitate the recording of the steps that have been taken to remediate or manage a child's behavioral or emotional problem(s). It also includes a section to record the fidelity of the intervention approach that has been used, a factor that is critical to the success of any intervention program.
CONTENT SCALE AND INDEX T-SCORE PROFILE

T Score (Plotted)

- General Combined: 59, 46, 49, 65, 60, 64, 42, 64, 54, 57, 53

Percentile

- General Combined: 81, 42, 54, 92, 83, 91, 22, 91, 75, 78, 67
Content Scale Score Table: General Combined Norm Group

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<thead>
<tr>
<th>Scale</th>
<th>Raw Score</th>
<th>T Score</th>
<th>Percentile Rank</th>
<th>90% Confidence Interval</th>
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Content Scale Narratives

Sample's T score on Anger Control is 59 and has a percentile rank of 81. Sample's mother reports that Sample regulates her affect and self-control under adverse conditions as well as others her age.

Sample's T score on Bullying is 46 and has a percentile rank of 42. Sample's mother reports that Sample does not tend to act in a threatening or intrusive manner.

Sample's T score on Developmental Social Disorders is 49 and has a percentile rank of 54. Sample's mother reports that Sample has social and communication skills that are typical of others her age.

Sample's T score on Emotional Self-Control is 65 and has a percentile rank of 92. This T score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample can become easily upset, frustrated, and/or angered in response to environmental changes.

Sample's T score on Executive Functioning is 60 and has a percentile rank of 83. This T score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample sometimes has difficulty controlling and maintaining her behavior and mood.

Sample's T score on Negative Emotionality is 64 and has a percentile rank of 91. This T score falls in the At-Risk classification range and follow-up may be necessary. Sample's mother reports that Sample has a tendency to react negatively when faced with changes in everyday activities or routines.

Sample's T score on Resiliency is 42 and has a percentile rank of 22. Sample's mother reports that Sample is able to overcome stress and adversity about as well as others her age.
EXECUTIVE FUNCTIONING INDEX SUMMARY

<table>
<thead>
<tr>
<th>Overall Executive Functioning Index</th>
<th>Problem Solving Index</th>
<th>Attentional Control Index</th>
<th>Behavioral Control Index</th>
<th>Emotional Control Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Elevated</td>
<td>Not Elevated</td>
<td>Elevated</td>
<td>Elevated</td>
<td>Not Elevated</td>
</tr>
<tr>
<td>Raw Score: 38</td>
<td>Raw Score: 11</td>
<td>Raw Score: 13</td>
<td>Raw Score: 11</td>
<td>Raw Score: 3</td>
</tr>
</tbody>
</table>

EXECUTIVE FUNCTIONING INDEX NARRATIVES

Sample's Overall Executive Functioning Index score is 38. This score falls in the Not Elevated classification range. Summary information for problem solving, attentional control, behavioral control, and emotional control is provided below.

Sample's Problem Solving Index score is 11. This score falls in the Not Elevated classification range.

Sample's Attentional Control Index score is 13. This score falls in the Elevated classification range and follow-up may be necessary. Anne reports that Sample sometimes has trouble concentrating, following directions, and may have a tendency to make careless mistakes.

Sample's Behavioral Control Index score is 11. This score falls in the Elevated classification range and follow-up may be necessary. Anne reports that Sample sometimes has difficulty maintaining her self-control and has difficulty regulating impulsive behaviors.

Sample's Emotional Control Index score is 3. This score falls in the Not Elevated classification range.
CLINICAL SUMMARY NARRATIVES

The BASC-3 items endorsed by Sample's parent/guardian resulted in a clinically significant Hyperactivity scale score, a pattern that occurred in 4.7% of the standardization sample. Children with this profile may exhibit problems with behavioral regulation and may be overactive, impulsive, and disruptive. Given this profile, possible diagnostic considerations might include attention-deficit/hyperactivity disorder (ADHD). These problems are likely to occur across multiple settings (e.g., school, home) and to be worse in situations requiring sustained mental effort.

Sample's profile is characterized by an at-risk Attention Problems scale score in addition to a clinically significant Hyperactivity scale score. In making diagnostic considerations regarding the possibility of ADHD, such a profile is probably more consistent with a diagnosis of ADHD combined presentation, as opposed to predominantly hyperactive/impulsive or inattentive presentation.

Sample also exhibited an elevation on the BASC-3 internalizing scale of Depression, a pattern that occurred in 64.7% of the BASC-3 standardization sample with a clinically significant Hyperactivity scale score. This profile indicates that she is experiencing increased levels of internal distress characterized by depressed mood, and additional diagnostic considerations are likely to include depressive disorders (e.g., major depressive disorder, bipolar disorder). Children with these problems may exhibit inattention and restlessness, which can appear behaviorally similar to ADHD. Furthermore, it may be the case that emotional distress is causing Sample to act out, or that negative feedback related to her behavioral issues is resulting in these internalizing problems. Thus, further investigation is warranted in order to clarify the complex relationship between her various behavioral and mood symptoms.

If it is believed that Sample is exhibiting comorbid mood and behavioral problems, the following considerations may be helpful. With respect to ADHD, it is useful to note that symptoms of hyperactivity or inattention are typically present before age 7 in ADHD, whereas the onset of these behaviors may occur later in mood disorders. Furthermore, children with ADHD are likely to exhibit these symptoms in situations that require sustained effort but are motivated by highly reinforcing activities. Conversely, individuals with depression may be more likely to exhibit poor motivation and behavioral agitation even while engaged with pleasurable activities. ADHD can be diagnosed with mood difficulties if criteria for both diagnoses are met. In these cases, it is important to note that restlessness and inattention are typically rated positively for mood disorders only in cases where they are significantly worse during periods of mood disturbance relative to what is accounted for by ADHD alone.

Children who experience difficulties with hyperactivity and attention problems present a unique challenge to parents. They may require frequent redirection, more consistent parenting practices, and stronger reinforcements/consequences in order to manage their behavior. The relationship can be characterized by communication and problem-solving deficits, and the parent and child may experience fewer feelings of warmth and closeness. Parents may also struggle with discipline and feel frustrated, and thus family involvement is often a core component of interventions for behavioral problems. Thus, an evaluation of the parent-child relationship (e.g., using the BASC-3 Parenting Relationship Questionnaire) might be helpful in developing and implementing a comprehensive treatment plan. Specifically, identifying areas of weakness in the parent-child relationship (e.g., conflict, communication) might help the therapist prioritize treatment goals.
DSM-5™ DIAGNOSTIC CRITERIA

Listed below are DSM-5 Diagnostic Criteria based on the ratings obtained from Anne on the PRS-C rating form. Each section first presents a list of symptoms of the disorder, along with PRS-C items that correspond to these symptoms. Then related DSM-5 criteria and codes are presented. While information from PRS-C items will likely be helpful for making a diagnosis, clinicians are strongly encouraged to use additional information that is gathered outside of the BASC-3 PRS-C form (e.g., observations of behavior, clinical interviews) when making a formal diagnosis. Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (Copyright © 2013).

Attention-Deficit/Hyperactivity Disorder (ADHD)

List of Symptoms

<table>
<thead>
<tr>
<th>Symptoms for ADHD: Inattention</th>
<th>Relevant BASC-3 PRS-C Items and Anne Sample’s Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not pay close attention to details, or makes careless mistakes</td>
<td></td>
</tr>
</tbody>
</table>
| X Has difficulty sustaining attention | 1. Pays attention. (Sometimes)  
11. Has a short attention span. (Often) |
| X Does not seem to listen when spoken to | 28. Listens to directions. (Sometimes)  
83. Listens carefully. (Never)  
127. Pays attention when being spoken to. (Often) |
| Does not follow through on instructions and fails to finish tasks | |
| Has trouble organizing activities/tasks | |
| Dislikes/avoids tasks that involve sustained mental effort | |
| Loses necessary materials | |
| Is easily distracted | 91. Is easily distracted. (Sometimes) |
| Is often forgetful | |

BASC™-3 Parent Rating Scales - Child Interpretive Summary Report with Intervention Recommendations  
07/17/2015, Page 22  
Sample Examinee
## Symptoms for ADHD: Hyperactivity/Impulsivity

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Relevant BASC-3 PRS-C Items and Anne Sample’s Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Fidgets or squirms excessively</td>
<td>93. Fiddles with things while at meals. (Often)</td>
</tr>
<tr>
<td>__ Leaves seat inappropriately</td>
<td></td>
</tr>
<tr>
<td>X Feels restless</td>
<td>151. Is unable to slow down. (Often)</td>
</tr>
<tr>
<td>__ Has difficulty engaging in activities</td>
<td></td>
</tr>
<tr>
<td>quietly</td>
<td></td>
</tr>
<tr>
<td>X Acts as if &quot;driven by a motor&quot;</td>
<td>32. Is overly active. (Often)</td>
</tr>
<tr>
<td></td>
<td>73. Has poor self-control. (Often)</td>
</tr>
<tr>
<td></td>
<td>166. Acts out of control. (Often)</td>
</tr>
<tr>
<td>__ Talks excessively</td>
<td></td>
</tr>
<tr>
<td>X Blurs out answers</td>
<td>24. Acts without thinking. (Often)</td>
</tr>
<tr>
<td>X Has trouble waiting her turn</td>
<td>172. Cannot wait to take turn. (Often)</td>
</tr>
<tr>
<td>X Interrupts others' conversations or</td>
<td>42. Interrupts others when they are speaking. (Often)</td>
</tr>
<tr>
<td>activities</td>
<td>114. Disrupts other children's activities. (Often)</td>
</tr>
<tr>
<td></td>
<td>159. Interrupts parents when they are talking on the</td>
</tr>
<tr>
<td></td>
<td>phone. (Often)</td>
</tr>
</tbody>
</table>

### DSM-5 Codes and Diagnostic Criteria

**Attention-Deficit/Hyperactivity Disorder (ADHD) 314.0x (F90.x)**

See the Q-global Resource Library for a reprint of the *DSM-5* Diagnostic Criteria for ADHD.
**Major Depressive Disorder**

List of Symptoms

<table>
<thead>
<tr>
<th>Symptoms for Major Depressive Episode</th>
<th>Relevant BASC-3 PRS-C Items and Anne Sample’s Responses</th>
</tr>
</thead>
</table>
| X Depressed (or irritable in children/adolescents) mood most of the day, almost every day | 4. Is easily upset. (Sometimes)  
34. Cries easily. (Sometimes)  
60. Is sad. (Often)  
100. Seems lonely. (Often) |
| -- Greatly decreased interest or pleasure in all, or almost all, activities most of the day, almost every day | 36. Avoids exercise or other physical activity. (Never) |
| -- Significant weight gain/loss (change of more than 5% of body weight in a month) without dieting, or increase/decrease in appetite almost every day (*Note.* For children, failure to make expected weight gains) | |
| -- Insomnia or excessive sleep almost every day | |
| -- Observable psychomotor agitation/retardation almost every day | |
| -- Fatigue/loss of energy almost every day | |
| X Feelings of worthlessness or excessive/inappropriate guilt almost every day | 45. Says, "I hate myself." (Sometimes) |
| -- Difficulty thinking, concentrating, or making decisions almost every day | 142. Makes decisions easily. (Often) |
| -- Recurrent thoughts about death or suicide, a suicide attempt, or a specific suicide plan | 52. Says, "I want to die" or "I wish I were dead." (Never)  
124. Says, "I want to kill myself." (Never) |

**DSM-5 Codes and Diagnostic Criteria**

**Major Depressive Disorder 296.xx (F32.x and F33.x)**

See the Q-global Resource Library for a reprint of the *DSM-5* Diagnostic Criteria for Major Depressive Disorder.
Disruptive Mood Dysregulation Disorder

List of Symptoms

<table>
<thead>
<tr>
<th>Symptoms for Disruptive Mood Dysregulation Disorder</th>
<th>Relevant BASC-3 PRS-C Items and Anne Sample’s Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area 1: Severe, Recurrent Temper Outbursts</strong></td>
<td></td>
</tr>
<tr>
<td>___ Has verbally or physically aggressive temper outbursts</td>
<td>26. Loses control when angry. (Sometimes)</td>
</tr>
<tr>
<td></td>
<td>41. Throws or breaks things when angry. (Never)</td>
</tr>
<tr>
<td></td>
<td>44. Overreacts to stressful situations. (Sometimes)</td>
</tr>
<tr>
<td><strong>Area 2: Mood Between Temper Outbursts</strong></td>
<td></td>
</tr>
<tr>
<td>X Persistently irritable or angry mood between temper outbursts</td>
<td>119. Is irritable. (Often)</td>
</tr>
<tr>
<td></td>
<td>147. Is easily stressed. (Sometimes)</td>
</tr>
</tbody>
</table>

DSM-5 Codes and Diagnostic Criteria

Disruptive Mood Dysregulation Disorder 296.99 (F34.8)

See the Q-global Resource Library for a reprint of the DSM-5 Diagnostic Criteria for Disruptive Mood Dysregulation Disorder.
### Persistent Depressive Disorder

#### List of Symptoms

<table>
<thead>
<tr>
<th>Area 1: Depressed Mood</th>
<th>Relevant BASC-3 PRS-C Items and Anne Sample’s Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Depressed mood</td>
<td>34. Cries easily. (Sometimes)</td>
</tr>
<tr>
<td></td>
<td>100. Seems lonely. (Often)</td>
</tr>
<tr>
<td></td>
<td>110. Is negative about things. (Often)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area 2: Symptoms Associated With Depressed Mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Poor self-esteem</td>
</tr>
<tr>
<td>(Sometimes)</td>
</tr>
<tr>
<td>45. Says, &quot;I hate myself.&quot;</td>
</tr>
<tr>
<td>80. Says, &quot;I don't have any friends.&quot; (Often)</td>
</tr>
<tr>
<td>129. Says, &quot;Nobody likes me.&quot; (Never)</td>
</tr>
</tbody>
</table>

X Difficulty making decisions or concentrating

11. Has a short attention span. (Often)
11. Is easily distracted. (Sometimes)
142. Makes decisions easily. (Often)

__ Feeling hopeless

4. Is easily upset. (Sometimes)

__ Overeating or decreased appetite

__ Insomnia or excessive sleep

__ Fatigue or decreased energy

**DSM-5 Codes and Diagnostic Criteria**

**Persistent Depressive Disorder 300.4 (F34.1)**

See the Q-global Resource Library for a reprint of the DSM-5 Diagnostic Criteria for Persistent Depressive Disorder.
TARGET BEHAVIORS FOR INTERVENTION

The behaviors listed below were identified by the rater as being particularly problematic. These behaviors may be appropriate targets for intervention or treatment. It can be useful to readminister the BASC-3 in the future to determine progress toward meeting the associated behavioral objectives.

General Behavior Issues
172. Cannot wait to take turn. (Often)

23. Lies. (Sometimes)
50. Teases others. (Sometimes)
65. Is cruel to animals. (Sometimes)

Academic Behavior Issues
114. Disrupts other children’s activities. (Often)

Adaptive/Social Behavior Issues
42. Interrupts others when they are speaking. (Often)
148. Is clear when telling about personal experiences. (Sometimes)
CRITICAL ITEMS

This area presents items that may be of particular interest when responses include Sometimes, Often, or Almost always.

13. Is a picky eater. (Never)
19. Has toileting accidents. (Never)
26. Loses control when angry. (Sometimes)
35. Threatens to hurt others. (Never)
36. Avoids exercise or other physical activity. (Never)
45. Says, "I hate myself." (Sometimes)
51. Eats things that are not food. (Never)
52. Says, "I want to die" or "I wish I were dead." (Never)
55. Hurts others on purpose. (Never)
58. Confuses real with make-believe. (Never)
65. Is cruel to animals. (Sometimes)
72. Falls down or trips over things easily. (Never)
75. Sleeps with parents. (Never)
82. Wets bed. (Never)
89. Sets fires. (Never)
98. Hits other children. (Never)
108. Picks on others who are different from his or her self. (Never)
117. Bullies others. (Never)
124. Says, "I want to kill myself." (Never)
131. Throws up after eating. (Never)
136. Has panic attacks. (Never)
140. Has seizures. (Never)
162. Runs away from home. (Never)
ITEMS BY SCALE - CLINICAL SCALES

Aggression
35. Threatens to hurt others. (Never)
41. Throws or breaks things when angry. (Never)
50. Teases others. (Sometimes)
59. Manipulates others. (Never)
98. Hits other children. (Never)
106. Gets back at others. (Never)
117. Bullies others. (Never)
121. Argues when denied own way. (Sometimes)
146. Is overly aggressive. (Never)

Anxiety
9. Worries. (Sometimes)
21. Is fearful. (Sometimes)
31. Appears tense. (Sometimes)
38. Worries about things that cannot be changed. (Sometimes)
54. Worries about what other children think. (Sometimes)
67. Worries about what parents think. (Sometimes)
84. Is nervous. (Sometimes)
104. Says, "It's all my fault." (Sometimes)
107. Worries about what teachers think. (Sometimes)
112. Says, "I'm not very good at this." (Sometimes)
128. Worries about making mistakes. (Sometimes)
136. Has panic attacks. (Never)
147. Is easily stressed. (Sometimes)
160. Says, "I'm afraid I will make a mistake." (Sometimes)

Attention Problems
1. Pays attention. (Sometimes)
11. Has a short attention span. (Often)
28. Listens to directions. (Sometimes)
83. Listens carefully. (Never)
91. Is easily distracted. (Sometimes)
127. Pays attention when being spoken to. (Often)
175. Has trouble concentrating. (Often)

Atypicality
12. Acts confused. (Never)
17. Seems odd. (Never)
58. Confuses real with make-believe. (Never)
81. Seems out of touch with reality. (Never)
88. Stares blankly. (Never)
115. Acts strangely. (Never)
122. Says things that make no sense. (Never)
125. Acts as if other children are not there. (Never)
145. Does strange things. (Never)
152. Seems unaware of others. (Never)
157. Babbles to self. (Never)
158. Speech is confused or disorganized. (Never)
167. Shows feelings that do not fit the situation. (Never)
171. Does weird things. (Never)

**Conduct Problems**
3. Disobeys. (Never)
7. Gets into trouble. (Never)
23. Lies. (Sometimes)
43. Deceives others. (Never)
55. Hurts others on purpose. (Never)
68. Breaks the rules. (Never)
74. Breaks the rules just to see what will happen. (Never)
141. Lies to get out of trouble. (Never)
144. Steals. (Never)
164. Sneaks around. (Never)

**Depression**
4. Is easily upset. (Sometimes)
34. Cries easily. (Sometimes)
40. Changes moods quickly. (Often)
45. Says, "I hate myself." (Sometimes)
52. Says, "I want to die" or "I wish I were dead." (Never)
60. Is sad. (Often)
80. Says, "I don't have any friends." (Often)
100. Seems lonely. (Often)
110. Is negative about things. (Often)
116. Says, "I can't do anything right." (Often)
119. Is irritable. (Often)
124. Says, "I want to kill myself." (Never)
129. Says, "Nobody likes me." (Never)

**Hyperactivity**
32. Is overly active. (Often)
42. Interrupts others when they are speaking. (Often)
73. Has poor self-control. (Often)
93. Fiddles with things while at meals. (Often)
99. Is in constant motion. (Often)
114. Disrupts other children's activities. (Often)
151. Is unable to slow down. (Often)
159. Interrupts parents when they are talking on the phone. (Often)
166. Acts out of control. (Often)
172. Cannot wait to take turn. (Often)

**Somatization**
6. Gets sick. (Sometimes)
15. Complains about health. (Never)
20. Says, "I think I'm sick." (Sometimes)
39. Complains of being sick when nothing is wrong. (Never)
49. Complains of pain. (Never)
57. Vomits. (Sometimes)
63. Expresses fear of getting sick. (Never)
78. Has headaches. (Never)
105. Has fevers. (Never)
118. Complains of physical problems. (Never)
132. Complains of stomach pain. (Never)
161. Is afraid of getting sick. (Never)

**Withdrawal**
- 48. Is shy with other children. (Never)
- 87. Quickly joins group activities. (Never)
- 96. Avoids other children. (Never)
- 101. Is shy with adults. (Never)
- 111. Has trouble making new friends. (Never)
- 126. Isolates self from others. (Never)
- 156. Avoids making friends. (Never)
- 163. Makes friends easily. (Never)
- 170. Prefers to play alone. (Sometimes)

**ITEMS BY SCALE - ADAPTIVE SCALES**

**Activities of Daily Living**
- 22. Makes healthy food choices. (Often)
- 27. Has trouble following regular routines. (Often)
- 37. Sets realistic goals. (Often)
- 46. Is careless with belongings. (Often)
- 64. Has trouble fastening buttons on clothing. (Never)
- 66. Needs to be reminded to brush teeth. (Never)
- 90. Cleans up after self. (Almost always)
- 149. Organizes chores or other tasks well. (Often)
- 153. Acts in a safe manner. (Almost always)

**Adaptability**
- 47. Adjusts well to changes in family plans. (Often)
- 86. Accepts things as they are. (Often)
- 92. Recovers quickly after a setback. (Often)
- 103. Adjusts well to changes in routine. (Often)
- 130. Handles winning and losing well. (Often)
- 133. Is easy to please. (Sometimes)
- 135. Is easily calmed when angry. (Often)
- 143. Adjusts well to new teachers. (Sometimes)

**Functional Communication**
- 5. Responds appropriately when asked a question. (Almost always)
- 33. Accurately takes down messages. (Almost always)
- 56. Tracks down information when needed. (Almost always)
- 61. Answers telephone properly. (Almost always)
- 69. Has difficulty explaining rules of games to others. (Sometimes)
- 76. Communicates clearly. (Almost always)
- 85. Has trouble getting information when needed. (Sometimes)
- 102. Likes to talk about his or her day. (Sometimes)
- 109. Starts conversations. (Often)
- 148. Is clear when telling about personal experiences. (Sometimes)
- 165. Is able to describe feelings accurately. (Almost always)
- 168. Is unclear when presenting ideas. (Sometimes)
Leadership
18. Is a "self-starter." (Sometimes)
29. Is usually chosen as a leader. (Never)
62. Is good at getting people to work together. (Never)
120. Gives good suggestions for solving problems. (Sometimes)
142. Makes decisions easily. (Often)
155. Prefers to be a leader. (Never)
173. Is highly motivated to succeed. (Sometimes)

Social Skills
2. Makes positive comments about others. (Often)
14. Says, "please" and "thank you." (Almost always)
53. Shows interest in others' ideas. (Sometimes)
77. Compliments others. (Often)
97. Makes others feel welcome. (Often)
113. Tries to help others be their best. (Sometimes)
134. Accepts people who are different from his or her self. (Almost always)
137. Offers help to other children. (Often)
154. Encourages others to do their best. (Sometimes)
174. Congratulates others when good things happen to them. (Often)

ITEMS BY SCALE - CONTENT SCALES

Anger Control
26. Loses control when angry. (Sometimes)
35. Threatens to hurt others. (Never)
40. Changes moods quickly. (Often)
41. Throws or breaks things when angry. (Never)
70. Gets angry easily. (Never)
73. Has poor self-control. (Often)
119. Is irritable. (Often)
121. Argues when denied own way. (Sometimes)
135. Is easily calmed when angry. (Often)

Bullying
35. Threatens to hurt others. (Never)
43. Deceives others. (Never)
50. Teases others. (Sometimes)
55. Hurts others on purpose. (Never)
59. Manipulates others. (Never)
94. Puts others down. (Never)
106. Gets back at others. (Never)
108. Picks on others who are different from his or her self. (Never)
117. Bullies others. (Never)
150. Tells lies about others. (Never)

Developmental Social Disorders
5. Responds appropriately when asked a question. (Almost always)
10. Avoids eye contact. (Never)
30. Engages in repetitive movements. (Never)
47. Adjusts well to changes in family plans. (Often)
53. Shows interest in others’ ideas. (Sometimes)
58. Confuses real with make-believe. (Never)
76. Communicates clearly. (Almost always)
103. Adjusts well to changes in routine. (Often)
111. Has trouble making new friends. (Never)
115. Acts strangely. (Never)
125. Acts as if other children are not there. (Never)
126. Isolates self from others. (Never)
139. Shows basic emotions clearly. (Never)
148. Is clear when telling about personal experiences. (Sometimes)
152. Seems unaware of others. (Never)
157. Babbles to self. (Never)
165. Is able to describe feelings accurately. (Almost always)
167. Shows feelings that do not fit the situation. (Never)
170. Prefers to play alone. (Sometimes)

**Emotional Self-Control**
4. Is easily upset. (Sometimes)
21. Is fearful. (Sometimes)
34. Cries easily. (Sometimes)
40. Changes moods quickly. (Often)
44. Overreacts to stressful situations. (Sometimes)
73. Has poor self-control. (Often)
119. Is irritable. (Often)
138. Is overly emotional. (Sometimes)
147. Is easily stressed. (Sometimes)
166. Acts out of control. (Often)

**Executive Functioning**
1. Pays attention. (Sometimes)
11. Has a short attention span. (Often)
16. Plans well. (Sometimes)
37. Sets realistic goals. (Often)
44. Overreacts to stressful situations. (Sometimes)
56. Tracks down information when needed. (Almost always)
71. Takes a step-by-step approach to work. (Sometimes)
73. Has poor self-control. (Often)
91. Is easily distracted. (Sometimes)
92. Recovers quickly after a setback. (Often)
95. Finds ways to solve problems. (Sometimes)
120. Gives good suggestions for solving problems. (Sometimes)
121. Argues when denied own way. (Sometimes)
135. Is easily calmed when angry. (Often)
142. Makes decisions easily. (Often)
149. Organizes chores or other tasks well. (Often)
159. Interrupts parents when they are talking on the phone. (Often)
166. Acts out of control. (Often)
175. Has trouble concentrating. (Often)
Negative Emotionality
4. Is easily upset. (Sometimes)
25. Finds fault with everything. (Sometimes)
45. Says, "I hate myself." (Sometimes)
52. Says, "I want to die" or "I wish I were dead." (Never)
79. Reacts negatively. (Sometimes)
110. Is negative about things. (Often)
119. Is irritable. (Often)
121. Argues when denied own way. (Sometimes)

Resiliency
8. Has good coping skills. (Sometimes)
18. Is a "self-starter." (Sometimes)
56. Tracks down information when needed. (Almost always)
62. Is good at getting people to work together. (Never)
92. Recovers quickly after a setback. (Often)
95. Finds ways to solve problems. (Sometimes)
103. Adjusts well to changes in routine. (Often)
123. Overcomes problems. (Never)
169. Is resilient. (Often)

ITEMS BY SCALE - CLINICAL INDEXES

ADHD Probability
7. Gets into trouble. (Never)
11. Has a short attention span. (Often)
32. Is overly active. (Often)
83. Listens carefully. (Never)
90. Cleans up after self. (Almost always)
91. Is easily distracted. (Sometimes)
149. Organizes chores or other tasks well. (Often)
151. Is unable to slow down. (Often)
166. Acts out of control. (Often)
175. Has trouble concentrating. (Often)

Autism Probability
17. Seems odd. (Never)
30. Engages in repetitive movements. (Never)
48. Is shy with other children. (Never)
81. Seems out of touch with reality. (Never)
96. Avoids other children. (Never)
111. Has trouble making new friends. (Never)
125. Acts as if other children are not there. (Never)
126. Isolates self from others. (Never)
155. Prefers to be a leader. (Never)
158. Speech is confused or disorganized. (Never)
163. Makes friends easily. (Never)
168. Is unclear when presenting ideas. (Sometimes)
170. Prefers to play alone. (Sometimes)
EBD Probability

4. Is easily upset. (Sometimes)
18. Is a "self-starter." (Sometimes)
23. Lies. (Sometimes)
35. Threatens to hurt others. (Never)
40. Changes moods quickly. (Often)
43. Deceives others. (Never)
47. Adjusts well to changes in family plans. (Often)
52. Says, "I want to die" or "I wish I were dead." (Never)
53. Shows interest in others' ideas. (Sometimes)
55. Hurts others on purpose. (Never)
59. Manipulates others. (Never)
60. Is sad. (Often)
68. Breaks the rules. (Never)
74. Breaks the rules just to see what will happen. (Never)
79. Reacts negatively. (Sometimes)
87. Quickly joins group activities. (Never)
94. Puts others down. (Never)
98. Hits other children. (Never)
106. Gets back at others. (Never)
117. Bullies others. (Never)
119. Is irritable. (Often)
121. Argues when denied own way. (Sometimes)
124. Says, "I want to kill myself." (Never)
134. Accepts people who are different from his or her self. (Almost always)
137. Offers help to other children. (Often)
138. Is overly emotional. (Sometimes)
144. Steals. (Never)
150. Tells lies about others. (Never)
164. Sneaks around. (Never)
172. Cannot wait to take turn. (Often)

Functional Impairment

1. Pays attention. (Sometimes)
4. Is easily upset. (Sometimes)
5. Responds appropriately when asked a question. (Almost always)
7. Gets into trouble. (Never)
9. Worries. (Sometimes)
11. Has a short attention span. (Often)
12. Acts confused. (Never)
15. Complains about health. (Never)
22. Makes healthy food choices. (Often)
27. Has trouble following regular routines. (Often)
33. Accurately takes down messages. (Almost always)
34. Cries easily. (Sometimes)
38. Worries about things that cannot be changed. (Sometimes)
40. Changes moods quickly. (Often)
43. Deceives others. (Never)
48. Is shy with other children. (Never)
56. Tracks down information when needed. (Almost always)
61. Answers telephone properly.. (Almost always)
64. Has trouble fastening buttons on clothing. (Never)
66. Needs to be reminded to brush teeth. (Never)
69. Has difficulty explaining rules of games to others. (Sometimes)
73. Has poor self-control. (Often)
76. Communicates clearly. (Almost always)
79. Reacts negatively. (Sometimes)
81. Seems out of touch with reality. (Never)
85. Has trouble getting information when needed. (Sometimes)
87. Quickly joins group activities. (Never)
96. Avoids other children. (Never)
100. Seems lonely. (Often)
111. Has trouble making new friends. (Never)
122. Says things that make no sense. (Never)
135. Is easily calmed when angry. (Often)
137. Offers help to other children. (Often)
142. Makes decisions easily. (Often)
147. Is easily stressed. (Sometimes)
148. Is clear when telling about personal experiences. (Sometimes)
149. Organizes chores or other tasks well. (Often)
153. Acts in a safe manner. (Almost always)
163. Makes friends easily. (Never)
165. Is able to describe feelings accurately. (Almost always)
168. Is unclear when presenting ideas. (Sometimes)
172. Cannot wait to take turn. (Often)
174. Congratulates others when good things happen to them. (Often)

ITEMS BY SCALE - EXECUTIVE FUNCTIONING INDEX

Problem Solving Index
16. Plans well. (Sometimes)
37. Sets realistic goals. (Often)
56. Tracks down information when needed. (Almost always)
71. Takes a step-by-step approach to work. (Sometimes)
95. Finds ways to solve problems. (Sometimes)
120. Gives good suggestions for solving problems. (Sometimes)
142. Makes decisions easily. (Often)
149. Organizes chores or other tasks well. (Often)

Attentional Control Index
1. Pays attention. (Sometimes)
11. Has a short attention span. (Often)
28. Listens to directions. (Sometimes)
83. Listens carefully. (Never)
91. Is easily distracted. (Sometimes)
127. Pays attention when being spoken to. (Often)
175. Has trouble concentrating. (Often)

Behavioral Control Index
42. Interrupts others when they are speaking. (Often)
73. Has poor self-control. (Often)
121. Argues when denied own way. (Sometimes)
159. Interrupts parents when they are talking on the phone. (Often)
166. Acts out of control. (Often)

**Emotional Control Index**
44. Overreacts to stressful situations. (Sometimes)
70. Gets angry easily. (Never)
135. Is easily calmed when angry. (Often)
138. Is overly emotional. (Sometimes)

**Overall Executive Functioning Index**
1. Pays attention. (Sometimes)
11. Has a short attention span. (Often)
16. Plans well. (Sometimes)
28. Listens to directions. (Sometimes)
37. Sets realistic goals. (Often)
42. Interrupts others when they are speaking. (Often)
44. Overreacts to stressful situations. (Sometimes)
56. Tracks down information when needed. (Almost always)
70. Gets angry easily. (Never)
71. Takes a step-by-step approach to work. (Sometimes)
73. Has poor self-control. (Often)
83. Listens carefully. (Never)
91. Is easily distracted. (Sometimes)
95. Finds ways to solve problems. (Sometimes)
120. Gives good suggestions for solving problems. (Sometimes)
121. Argues when denied own way. (Sometimes)
127. Pays attention when being spoken to. (Often)
135. Is easily calmed when angry. (Often)
138. Is overly emotional. (Sometimes)
142. Makes decisions easily. (Often)
149. Organizes chores or other tasks well. (Often)
159. Interrupts parents when they are talking on the phone. (Often)
166. Acts out of control. (Often)
175. Has trouble concentrating. (Often)

*The Behavior Assessment System for Children, Third Edition (BASC-3) is an integrated system designed to facilitate the differential diagnosis and classification of a variety of emotional and behavioral disorders of children and to aid in the design of treatment plans. This computer-generated report should not be the sole basis for making important diagnostic or treatment decisions.*

**End of Report**

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## ITEM RESPONSES

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