

LEAD RISK ASSESSMENT QUESTIONNAIRE

Please check "Yes" or "No" for the following questions:

	YES	NO
1. Does your child live in a house/apartment that was built before 1960?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child live in a house/apartment that was built before 1978, that is being remodeled at this time?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does anyone living with your child ever had elevated <u>lead</u> levels?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does anyone living with your child work in a lead industry (radiator shop or battery manufacturer) or have a hobby that uses lead (welder, painter, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child eat paint chips or any non-food items or play in dirt where cars have been parked?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are home remedies such as greta, azarcon, or pay-loo-ah, or cosmetics with kohl in them used in your home?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does anyone in the family use cosmetics, ethnic or folk remedies, or eat candy from Mexico?	<input type="checkbox"/>	<input type="checkbox"/>
9. Is your child a recent immigrant, refugee, or a member of a minority group?	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS: If there is an answer to YES or UNKNOWN to any of the questions above.

Patient Name: _____

Date of Birth: _____

Age: _____

Provider's Signature: _____

Today's Date: _____

CARTERSVILLE PEDIATRIC ASSOCIATES

Patient Name: _____

Date of Birth: _____

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? Yes No
(FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)
2. Have you ever wondered if your child might be deaf? Yes No
3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) Yes No
4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs) Yes No
5. Does your child make unusual finger movements near his or her eyes? Yes No
(FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)
6. Does your child point with one finger to ask for something or to get help? Yes No
(FOR EXAMPLE, pointing to a snack or toy that is out of reach)
7. Does your child point with one finger to show you something interesting? Yes No
(FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)
8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?) Yes No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck) Yes No
10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) Yes No
11. When you smile at your child, does he or she smile back at you? Yes No
12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?) Yes No
13. Does your child walk? Yes No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? Yes No
15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do) Yes No
16. If you turn your head to look at something, does your child look around to see what you are looking at? Yes No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say “look” or “watch me”?) Yes No
18. Does your child understand when you tell him or her to do something? Yes No
(FOR EXAMPLE, if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?)
19. If something new happens, does your child look at your face to see how you feel about it? Yes No
(FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)
20. Does your child like movement activities? Yes No
(FOR EXAMPLE, being swung or bounced on your knee)

Provider Signature: _____

Date: _____

PATIENT NAME _____ DATE OF BIRTH _____

VISION RISK ASSESSMENT BIRTH TO 3 YEARS

1. Does your infant or child wear eye glasses? Y N
2. If so, when was their last eye exam? _____
3. Does your child seem to see well? Y N
4. Does your child hold objects close to their face when trying to focus? Y N
5. Do your child's eyes appear unusual or seem to cross, drift or be lazy? Y N
6. Do your child's eyelids droop or does one eyelid tend to close? Y N
7. Have your child's eyes ever been injured? Y N

(PHYSICIAN USE ONLY)

COMMENTS: NO SCREENING NEEDED

REFER TO OPHTHAMOLOGY

Eye Consultants of Atlanta
Scottish Rite 404-255-2419
Marietta 770-424-5669

Cartersville Pediatric Associates
958A Joe Frank Harris Pkwy
Cartersville, GA 30120

Provider Signature: _____

TUBERCULOSIS RISK ASSESSMENT QUESTIONNAIRE

Please check "Yes" or "No" for the following questions:

	YES	NO
1. Is your child in close contact of a person with infectious tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have HIV infection or is he/she considered at risk for HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is your child foreign born (especially Asian, African, Latin American), a refugee or a migrant?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is your child in contact with an incarcerated person or a person who was incarcerated in the past five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your child exposed to the following individuals: HIV infected, homeless individuals, residents of nursing home, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults or migrant farm workers?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have a medical condition or treatment of a medical condition which suppresses the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child live in a community in which it has been established that a high risk exists for tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
8. Other _____	<input type="checkbox"/>	<input type="checkbox"/>

(Individuals treated for tuberculosis or currently active should not be tested.)

Any "yes" answer means the child is high risk, should receive a tuberculin skin test (Mantoux) which should be read by a health professional and the Public Health Department should be notified.

(See section 902.2j)

Patient Name: _____

Date of Birth: _____

Age: _____

PROVIDER SIGNATURE: _____

Today's Date: _____

SCREENING FOR TB DISEASE AND INFECTION

- In general, high-risk groups that should be screened for infection include:
- Close contacts of persons with infectious TB;
- Persons with HIV infection or risk factors for HIV for unknown HIV status;
- Persons with certain medical conditions (including cancer of head and neck, Hematologic and Reticuloendothelial diseases, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndromes, prolonged corticosteroid therapy, and other immunosuppressive therapy);
- Persons who inject drugs;
- Foreign-born persons from areas of the world where TB is common (e.g., Asia, Africa, Latin American);
- Medically underserved low income populations, including high risk racial and ethnic groups (e.g., Asians, Pacific Islanders, Blacks, Hispanics, and Native Americans);
- Residents of long-term care facilities (e.g., correctional facilities and nursing homes); or
- Other groups identified locally as having an increased prevalence of TB (e.g., migrant Farm workers or homeless persons).

TUBERCULIN SKIN TESTING

Mantoux tuberculin skin testing is the standard method of identifying persons infected with *M. tuberculosis*. Multiple puncture tests should not be used to determine whether a person is infected.

The Mantoux test is performed by giving an intradermal injection of 0.1ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) into either the volar or dorsal surface of the forearm. The injection should be made with a disposable tuberculin syringe, just beneath the surface of the skin, with the needle bevel facing upward. This should produce a discrete, pale elevation of the skin (a wheal) 6mm to 10mm in diameter.

The reaction to the Mantoux test should be read by the trained health care worker 48 to 72 hours after the injection. If a patient fails to show up for the scheduled reading, a positive reaction may still be measurable up to 1 week after testing. However, if a patient who fails to return within 72 hours has a negative, tuberculin testing should be repeated.

The area of induration (palpable swelling) around the site of injection is the reaction to Tuberculin. The diameter of the indurated area should be measured across the forearm (perpendicular to the long axis). Erythema (redness) should not be measured. All reaction should be recorded in millimeters of induration, even those classified as negative. If no induration is found, "0mm" should be recorded.

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition

By Diane Bricker and Jane Squires

with assistance from *Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell*

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24 Month • 2 Year

Questionnaire



On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☒ Be sure to try each activity with your child before checking a box.
- ☒ Try to make completing this questionnaire a game that is fun for you and your child.
- ☒ Make sure your child is rested, fed, and ready to play.
- ☒ Please return this questionnaire by _____.
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: _____.
- ☒ Look forward to filling out another questionnaire in _____ months.



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24 Month • 2 Year **Questionnaire**

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

Administering program or provider: _____



At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, score "yes" for the item.

YES SOMETIMES NOT YET

COMMUNICATION




Be sure to try each activity with your child.

1. Without showing her first, does your child *point* to the correct picture when you say, "Show me the kitty" or ask, "Where is the dog?" (She needs to identify only one picture correctly.) ☐ ☐ ☐ ☐
 2. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Check "yes" even if his words are difficult to understand.) ☐ ☐ ☐ ☐
 3. Without giving her clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions? ☐ ☐ ☐ ☐
 - a. "Put the toy on the table." d. "Find your coat."
 - b. "Close the door." e. "Take my hand."
 - c. "Bring me a towel." f. "Get your book."
 4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture? ☐ ☐ ☐ ☐
 5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "Bye-bye," "All gone," "All right," and "What's that?") ☐ ☐ ☐ ☐
- Please give an example of your child's word combinations:
- _____
6. Does your child correctly use at least two words like "me," "I," "mine," and "you"? ☐ ☐ ☐ ☐

COMMUNICATION TOTAL ☐

GROSS MOTOR

Be sure to try each activity with your child.

1. Does your child walk down stairs if you hold onto one of his hands? (You can look for this at a store, on a playground, or at home.) ☐ ☐ ☐ ☐
2. When you show her how to kick a large ball, does your child try to kick the ball by moving her leg forward or by walking into it? (If your child already kicks a ball, check "yes" for this item.) ☐ ☐ ☐ ☐

3. Does your child walk either up or down at least two steps by himself? You can look for this at a store, on a playground, or at home. (Check "yes" even if he holds onto the wall or railing.) ☐ ☐ ☐ ☐

4. Does your child run fairly well, stopping herself without bumping into things or falling? ☐ ☐ ☐ ☐


YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

5. Does your child jump with both feet leaving the floor at the same time?



☐ ☐ ☐ _____

6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?



☐ ☐ ☐ _____ *

GROSS MOTOR TOTAL _____

**If gross motor item 6 is marked "yes" or "sometimes," mark gross motor item 2 as "yes."*

FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?

☐ ☐ ☐ _____

2. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)

☐ ☐ ☐ _____

3. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

☐ ☐ ☐ _____

4. Does your child flip switches off and on?

☐ ☐ ☐ _____

5. Does your child stack seven small blocks or toys on top of each other by himself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

☐ ☐ ☐ _____

6. Does your child thread a shoelace through either a bead or an eyelet of a shoe?



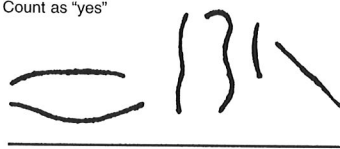
☐ ☐ ☐ _____

FINE MOTOR TOTAL _____

PROBLEM SOLVING *Be sure to try each activity with your child.*

1. After she watches you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in *any direction*? (Scribbling back and forth does not count as "yes.")

Count as "yes"



Count as "not yet"



☐ ☐ ☐ _____

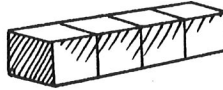
2. Without showing him how, does your child purposefully turn a small, clear bottle upside down to dump out a crumb or Cheerio? (You can use a soda-pop bottle or baby bottle.)

☐ ☐ ☐ _____

YES SOMETIMES NOT YET

PROBLEM SOLVING *(continued)*

3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it?
6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? (You can also use spools of thread, small boxes, or other toys.)



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. Does your child drink from a cup or glass, putting it down again with little spilling?
2. Does your child copy activities you do, such as wipe up a spill, sweep, shave, or comb hair?
3. Does your child eat with a fork?
4. When playing with either a stuffed animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?
5. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if he cannot turn?
6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___

PERSONAL-SOCIAL TOTAL ___

OVERALL *Parents and providers may use the space at the bottom of the next sheet for additional comments.*

1. Do you think your child hears well? YES ☐ NO ☐
If no, explain: _____
2. Do you think your child talks like other toddlers her age? YES ☐ NO ☐
If no, explain: _____

OVERALL (continued)

3. Can you understand most of what your child says? YES ☐ NO ☐
If no, explain: _____
4. Do you think your child walks, runs, and climbs like other toddlers his age? YES ☐ NO ☐
If no, explain: _____
5. Does either parent have a family history of childhood deafness or hearing impairment? YES ☐ NO ☐
If yes, explain: _____
6. Do you have any concerns about your child's vision? YES ☐ NO ☐
If yes, explain: _____
7. Has your child had any medical problems in the last several months? YES ☐ NO ☐
If yes, explain: _____
8. Does anything about your child worry you? YES ☐ NO ☐
If yes, explain: _____

24 Month/2 Year ASQ Information Summary

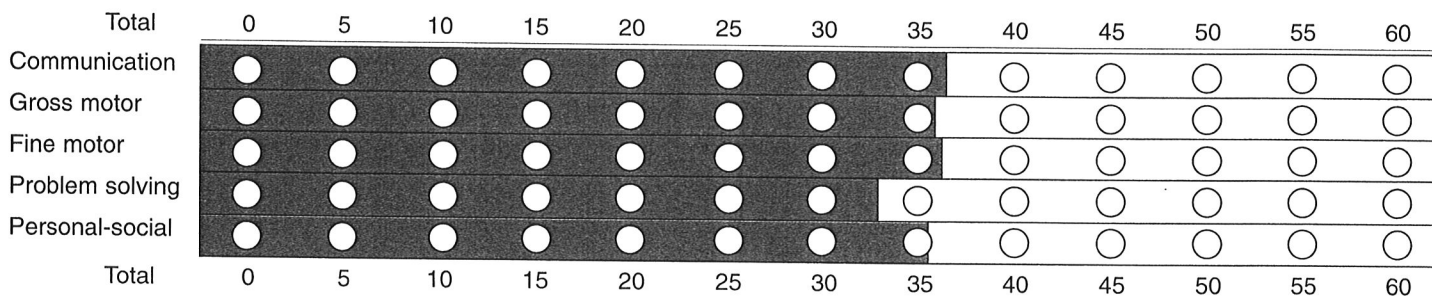
Child's name: _____ Date of birth: _____
 Person filling out the ASQ: _____ Relationship to child: _____
 Mailing address: _____ City: _____ State: _____ ZIP: _____
 Telephone: _____ Assisting in ASQ completion: _____
 Today's date: _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

- | | | | |
|--|--------|---|--------|
| 1. Hears well?
Comments: | YES NO | 5. Family history of hearing impairment?
Comments: | YES NO |
| 2. Talks like other toddlers?
Comments: | YES NO | 6. Vision concerns?
Comments: | YES NO |
| 3. Understand child?
Comments: | YES NO | 7. Recent medical problems?
Comments: | YES NO |
| 4. Walks, runs, and climbs like others?
Comments: | YES NO | 8. Other concerns?
Comments: | YES NO |

SCORING THE QUESTIONNAIRE

- Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide*.
- Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
 YES = 10 SOMETIMES = 5 NOT YET = 0
- Add up the item scores for each area, and record these totals in the space provided for area totals.
- Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

- If the child's total score falls within the ☐ area, the child appears to be doing well in this area at this time.
- If the child's total score falls within the ☒ area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

Score Cutoff		Communication	Gross motor	Fine motor	Problem solving	Personal-social	
24 months/2 years	Communication	36.5	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Gross motor	36.0	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Fine motor	36.4	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Problem solving	32.9	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Personal-social	35.6	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>
			6 <input type="radio"/> <input type="radio"/> <input type="radio"/>	6 <input type="radio"/> <input type="radio"/> <input type="radio"/>	6 <input type="radio"/> <input type="radio"/> <input type="radio"/>	6 <input type="radio"/> <input type="radio"/> <input type="radio"/>	6 <input type="radio"/> <input type="radio"/> <input type="radio"/>
		Y S N	Y S N	Y S N	Y S N	Y S N	

Administering program or provider: _____