Name: ______________________ DOB:______________ Date: ________________

# 12 Months (11 Months 0 days through 12 months 30 days)

## COMMUNICATION

| | YES | SOMETIMES | NOT YET | |
|---|---|---|---|---|
| 1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)* | ○ | ○ | ○ | ___ |
| 2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")? | ○ | ○ | ○ | ___ |
| 3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures? | ○ | ○ | ○ | ___ |
| 4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? *(A "word" is a sound or sounds your baby says consistently to mean someone or something.)* | ○ | ○ | ○ | ___ |
| 5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? *(Make sure the object is present. Mark "yes" if she knows one object.)* | ○ | ○ | ○ | ___ |
| 6. When your baby wants something, does he tell you by *pointing* to it? | ○ | ○ | ○ | ___ |

COMMUNICATION TOTAL ____

## GROSS MOTOR

| | YES | SOMETIMES | NOT YET | |
|---|---|---|---|---|
| 1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position? | ○ | ○ | ○ | ___ |
| 2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)? | ○ | ○ | ○ | ___ |
| 3. Does your baby walk beside furniture while holding on with only one hand? | ○ | ○ | ○ | ___ |
| 4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? *(If your baby already walks alone, mark "yes" for this item.)* | ○ | ○ | ○ | ___ |
| 5. When you hold *one hand* just to balance your baby, does she take several steps forward? *(If your baby already walks alone, mark "yes" for this item.)* | ○ | ○ | ○ | ___ |
| 6. Does your baby stand up in the middle of the floor by himself and take several steps forward? | ○ | ○ | ○ | ___ |

GROSS MOTOR TOTAL ____

## FINE MOTOR

| | YES | SOMETIMES | NOT YET | |
|---|---|---|---|---|
| 1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? *(The string may be attached to a toy.)* | ○ | ○ | ○ | ___ |
| 2. Does your baby pick up a crumb or Cheerio with the *tips* of her thumb and a finger? She may rest her arm or hand on the table while doing it. | ○ | ○ | ○ | ___ |
| 3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy? | ○ | ○ | ○ | ___ |
| 4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the *tips* of her thumb and a finger? | ○ | ○ | ○ | ___ |
| 5. Does your baby throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* | ○ | ○ | ○ | ___ |
| 6. Does your baby help turn the pages of a book? *(You may lift a page for him to grasp.)* | ○ | ○ | ○ | ___ |

FINE MOTOR TOTAL ____

## PROBLEM SOLVING

| | YES | SOMETIMES | NOT YET | |
|---|---|---|---|---|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? | ○ | ○ | ○ | ___ |
| 2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)? | ○ | ○ | ○ | ___ |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? *(Be sure the toy is completely hidden.)* | ○ | ○ | ○ | ___ |
| 4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? *(If she already lets go of the toy into a bowl or box, mark "yes" for this item.)* | ○ | ○ | ○ | ___ |
| 5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? *(You may show him how to do it.)* | ○ | ○ | ○ | ___ |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? *(If she already scribbles on her own, mark "yes" for this item.)* | ○ | ○ | ○ | ___ |

PROBLEM SOLVING TOTAL ___

## PERSONAL-SOCIAL

| | YES | SOMETIMES | NOT YET | |
|---|---|---|---|---|
| 1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? *(If he already lets go of the toy into your hand, mark "yes" for this item.)* | ○ | ○ | ○ | ___ |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve? | ○ | ○ | ○ | ___ |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand? | ○ | ○ | ○ | ___ |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | ○ | ○ | ○ | ___ |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him? | ○ | ○ | ○ | ___ |
| 6. Does your baby play with a doll or stuffed animal by hugging it? | ○ | ○ | ○ | ___ |

PERSONAL-SOCIAL TOTAL ___

**SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

| Area | Cutoff | Total Score | 0 | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Communication | 15.64 | | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Gross Motor | 21.49 | | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Fine Motor | 34.50 | | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Problem Solving | 27.32 | | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Personal-Social | 21.73 | | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

# Patient History Form - Newborn to 5 years

**Patient Name**________________________________ **DOB**______________

**Sex M F History given by**______________________________ **Date**______________

**Patient Information:**

**Are immunizations up to date? Yes or No**

**Birth History**: Was infant born early or late? Yes or No

If yes, how many weeks? ______________________

What was infants birth weight? ______________________

Did your child have any respiratory problems, jaundice, or other problems at birth?

______________________________________________

**Acute Illness / Chronic Illness / Medical Issues:** List all past and present diagnoses

______________________________________________

______________________________________________

**Hospitalizations or ER Visits:** List any that have occurred since the last well check

______________________________________________

______________________________________________

**Surgeries:** List any that have occurred since the last well check

______________________________________________

**Allergies:** ______________________________________________

**Medications**: name, dose, what is it given for?

______________________________________________

______________________________________________

**Social History**:

Who does the patient live with?

______________________________________________

If biological parents are separated or don't live in the same home as the patient, how often does the child visit the other home?

______________________________________________

Does your child have any pets in or outside of the home? Yes No

If yes, list pets: ______________________________

Does anyone in the household smoke or vape? ______________________________

Any recent travel since the last well check? Yes No Where? ______________________

**Family History** - **Please provide information for patient's parents, siblings and grandparents:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Problems/ Heart Attack | Y | N | Migraines/Headaches | Y | N | Allergies | Y | N |
| High Cholesterol | Y | N | ADHD/ADD | Y | N | Eczema | Y | N |
| High Blood Pressure | Y | N | Diabetes | Y | N | Depression or Anxiety | Y | N |
| Asthma | Y | N | Thyroid Problems | Y | N | Obesity | Y | N |
| Stomach Problems | Y | N | Bleeding or Clotting Problems | Y | N | Alcoholism | Y | N |
| Kidney/Bladder Problems | Y | N | Anemia | Y | N | Drug Abuse | Y | N |
| Seizures | Y | N | Arthritis | Y | N | Cancer | Y | N |

# Lead Risk Questionnaire

Form Pb-110

**Purpose:** To identify children who need to be tested for lead exposure.

## Instructions

- If **Yes or Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

**Patient's Name:** ____________________ **DOB:** __________ **Medicaid #:** __________

**Provider's Name:** ____________________ **Administered by:** ____________________ **Date** __________

## Questions

| Questions | Yes or Don't Know | No |
|---|---|---|
| 1. Does your child live in or visit a home, day-care or other building built before 1978? | ☐ | ☐ |
| 2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling? | ☐ | ☐ |
| 3. Does your child eat or chew on non-food things like paint chips or dirt? | ☐ | ☐ |
| 4. Does your child have a family member or friend who has or did have an elevated blood lead level? | ☐ | ☐ |
| 5. Is your child a newly arrived refugee or foreign adoptee? | ☐ | ☐ |
| 6. Does your child come in contact with an adult whose job or hobby involves lead exposure? | ☐ | ☐ |

*Examples*

- House construction or repair
- Battery manufacturing or repair
- Burning lead-painted wood
- Automotive repair shop or junk yard
- Going to a firing range or reloading bullets
- Chemical preparation
- Valve and pipe fittings
- Brass/copper foundry
- Refinishing furniture
- Making fishing weights
- Radiator repair
- Pottery making
- Lead smelting
- Welding

| Questions | Yes or Don't Know | No |
|---|---|---|
| 7. Does your family use products from other countries such as pottery, health remedies, spices, or food? | ☐ | ☐ |

*Examples*

- Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda
- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.
- Foods canned or packaged outside the U.S.

Test Immediately

**Fax this form to 512-776-7699 or mail to the address below.**

Texas Childhood Lead Poisoning Prevention Program • Texas Department of State Health Services
PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

Revised December 22, 2011

# Questions About Your Child and Tuberculosis (TB)

Child's Name ______________________ Date of Birth ______________

Your Name ______________________________

Today's Date ______________

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a TB skin test. The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

| **Check the box that matches your answer:** | Yes | No | Do Not Know |
|---|---|---|---|
| 1. Has your child been tested for TB?<br>If yes, when? Please tell us the date ______________ | | | |
| 2. Have you ever been told that your child had a positive TB skin test (TST)?<br>If yes, when? Please tell us the date ______________ | | | |
| 3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood. | | | |
| Has your child been around anyone with any of these problems? | | | |
| Has your child been around anyone sick with TB? | | | |
| Has your child ever had any of these problems or do they have them now? | | | |
| 4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia? | | | |
| 5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks?<br>Which country or countries did your child visit? ______________ | | | |
| 6. Do you know if your child has spent more than 3 weeks with anyone who: | | | |
| Uses needles for drug use? | | | |
| Has AIDS? | | | |
| Was or is in jail or prison? | | | |
| Has just come to the United States from another country? | | | |

---

**FOR THE PROVIDER:**

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.
If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.
If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

PPD administered Yes___ No___
If yes,
Date administered ____/____/____ Date read ____/____/____ PPD response__________ mm

PPD provider ______________________ ______________________
Signature Printed Name

If chest x-ray done, date and results
______________________________________________

Provider phone number__________________ City________________ County________________

If positive, referral to local/regional health department/specialist? Yes___ No___
If yes, name of health dept/specialist ______________________________

Contact your local or regional health department if assistance is needed.

# PEDS Response Form

Provider

*Child's Name* ______________________ *Parent's Name* ______________________

*Child's Birthday* ______________________ *Child's Age* ______________ *Today's Date* ______________

*Please list any concerns about your child's learning, development, and behavior.*

*Do you have any concerns about how your child talks and makes speech sounds?*

*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child understands what you say?*

*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child uses his or her hands and fingers to do things?*

*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child uses his or her arms and legs?*

*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child behaves?*

*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child gets along with others?*

*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child is learning to do things for himself/herself?*

*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child is learning preschool or school skills?*

*Circle one: No Yes A little COMMENTS:*

*Please list any other concerns.*

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