Name: _____ DOB:_____ Date: _____

24 Months (23 Months 0 days through 25 months 15 days)

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your showing him, 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? *(Mark "yes" even if her words are difficult to understand.)*	○	○	○	___
3. Without your giving him 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

	YES	SOMETIMES	NOT YET	
1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	○	○	○	___
2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)*	○	○	○	___
3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.	○	○	○	___
4. Does your child run fairly well, stopping herself without bumping into things or falling?	○	○	○	___
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 ____

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	○	○	○	___
2. Does your child turn the pages of a book by herself? *(She may turn more than one page at a time.)*	○	○	○	___
3. Does your child use a turning motion with his 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 herself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	___
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	○	○	○	___

FINE MOTOR TOTAL ____

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. After watching 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*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes" = 131 / Count as "not yet" = 28	○	○	○	___
2. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? *(Do not show him how.) (You can use a soda-pop bottle or baby bottle.)*	○	○	○	___
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 (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	___
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.)*	○	○	○	___

PROBLEM SOLVING TOTAL ____

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	___
2. Does your child copy the 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 a 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 wagon, stroller, or other toy on wheels, 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."	○	○	○	___

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	25.17		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

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

TEXAS Department of State Health Services

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

	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

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? If yes, when? Please tell us the date _____			
2. Have you ever been told that your child had a positive TB skin test (TST)? 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? 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.

M CHAT

www.m-chat.org

Child's name _____ Date _____

Age _____ Relationship to child _____

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

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? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
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? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
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? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**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?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

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.

#700PEDSv1-2009