Name: ______________________________ DOB:________________ Date: ___________________

48 Months (45 Months 0 days through 50 months 30 days)

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?	○	○	○	___
2. Does your child answer the following questions? *(Mark "sometimes" if your child answers only one question.)*	○	○	○	___

"What do you do when you are hungry?" *(Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.")* Please write your child's response:

"What do you do when you are tired?" *(Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.")* Please write your child's response:

	YES	SOMETIMES	NOT YET	
3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?	○	○	○	___
4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am play*ing*," or "I kick*ed* the ball"?	○	○	○	___
5. Without your giving help by pointing or repeating, does your child follow three directions that are *unrelated* to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."	○	○	○	___
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I *am* going to *the* park," or "*Is* there *a* toy to play with?" or "*Are* you coming, too?"	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child catch a large ball with both hands? *(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)*	○	○	○	___
2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?	○	○	○	___
3. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")*	○	○	○	___
4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling?	○	○	○	___
5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?	○	○	○	___
6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? *(You may give your child two or three tries before you mark the answer.)*	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child put together a five- to seven-piece interlocking puzzle? *(If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)*	○	○	○	___
2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? *(Carefully watch your child's use of scissors for safety reasons.)*	○	○	○	___
3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? *(Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)*	○	○	○	___

	YES	SOMETIMES	NOT YET	
4. Does your child unbutton one or more buttons? *(Your child may use his own clothing or a doll's clothing.)*	○	○	○	___
5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?	○	○	○	___
6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? *(Your child should not go more than 1/4 inch outside the lines on most of the picture.)*	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When you say, "Say 'five eight three,'" does your child repeat *just* the three numbers in the same order? *Do not repeat the numbers.* If necessary, try another series of numbers and say, "Say 'six nine two.'" *(Your child must repeat just one series of three numbers to answer "yes" to this question.)*	○	○	○	___
2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? *(Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)*	○	○	○	___

	YES	SOMETIMES	NOT YET	
3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "*under* the couch." Then ask her to put the ball "*between* the chairs" and the book "in the *middle* of the table."	○	○	○	___
4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? *(Mark "yes" only if your child answers the question correctly using five colors.)*	○	○	○	___
5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure.	○	○	○	___
6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? *(Ask this question without providing help by pointing, gesturing, or naming.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

Name: ____________________ DOB: ____________ Date: ______________

48 Months (45 Months 0 days through 50 months 30 days)

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?	○	○	○	___
2. Does your child tell you at least four of the following? Please mark the items your child knows.	○	○	○	___

○ a. First name ○ d. Last name

○ b. Age ○ e. Boy or girl

○ c. City she lives in ○ f. Telephone number

	YES	SOMETIMES	NOT YET	
3. Does your child wash his hands using soap and water and dry off with a towel without help?	○	○	○	___
4. Does your child tell you the names of two or more playmates, not including brothers and sisters? *(Ask this question without providing help by suggesting names of playmates or friends.)*	○	○	○	___
5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? *(You may still need to check and rebrush your child's teeth.)*	○	○	○	___
6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)?	○	○	○	___

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	30.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○

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

Question	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?	☐	☐
7. Does your family use products from other countries such as pottery, health remedies, spices, or food?	☐	☐

Examples for question 6:

- 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

Examples for question 7:

- 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.

TEXAS Department of State Health Services

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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#700PEDSv1-2009