Developmental Milestones Checklist *

Child's Name _____ **DOB** _____

4 Years

- ☐ Sings a song
- ☐ Draws person with three parts
- ☐ Distinguishes fantasy and reality
- ☐ Gives first and last name
- ☐ Builds 10 block tower
- ☐ Hops on one foot
- ☐ Throws overhand ball

Date _____ Signature _____

5 Years

- ☐ Dresses self without help
- ☐ Learns address and phone number
- ☐ Can count on fingers
- ☐ Copies triangle or square
- ☐ Draws person with head, arms and legs
- ☐ Recognizes most letters and can print some
- ☐ Plays make-believe

Date _____ Signature _____

6 Years

- ☐ Ties his/her own shoes
- ☐ Dresses self completely without help
- ☐ Catches a small bouncing ball, such as a tennis ball, with only one hand
- ☐ Can tell age correctly
- ☐ Repeats at least four numbers in a proper sequence
- ☐ Skips on both feet

Date _____ Signature _____

7-10 Years

- ☐ School adjustment
- ☐ School performance
- ☐ Family
- ☐ Friends
- ☐ Activities outside of school

Date _____ Signature _____

11-21 Years

- ☐ Sexual development and behaviors (abstinence, STD prevention, BC)
- ☐ Tobacco/Alcohol/Substance/Anabolic steroid use/avoidance
- ☐ Body image and dieting patterns
- ☐ Emotional, physical and sexual abuse
- ☐ Emotional (Depression, Anxiety)
- ☐ School/Work problems
- ☐ Peer relationships
- ☐ Family relationships

Date _____ Signature _____

Reference: Bright Futures

***Note: This resource is not a standardized, validated screening tool.**

01/13/05

A Survey From Your Healthcare Provider — PSC-Y

Name	DOB	Date

	Please mark under the heading that best fits you or circle Yes or No	Never 0	Sometimes 1	Often 2
-	1. Complain of aches or pains			
-	2. Spend more time alone			
-	3. Tire easily, little energy			
●	4. Fidgety, unable to sit still			
-	5. Have trouble with teacher			
-	6. Less interested in school			
●	7. Act as if driven by motor			
●	8. Daydream too much			
●	9. Distract easily			
-	10. Are afraid of new situations			
▲	11. Feel sad, unhappy			
-	12. Are irritable, angry			
▲	13. Feel hopeless			
●	14. Have trouble concentrating			
-	15. Less interested in friends			
■	16. Fight with other children			
-	17. Absent from school			
-	18. School grades dropping			
▲	19. Down on yourself			
-	20. Visit doctor with doctor finding nothing wrong			
-	21. Have trouble sleeping			
▲	22. Worry a lot			
-	23. Want to be with parent more than before			
-	24. Feel that you are bad			
-	25. Take unnecessary risks			
-	26. Get hurt frequently			
▲	27. Seem to be having less fun			
-	28. Act younger than children your age			
■	29. Do not listen to rules			
-	30. Do not show feelings			
■	31. Do not understand other people's feelings			
■	32. Tease others			
■	33. Blame others for your troubles			
■	34. Take things that do not belong to you			
■	35. Refuse to share			
◆	36. During the past three months, have you thought of killing yourself?		Yes	No
◆	37. Have you ever tried to kill yourself?		Yes	No

FOR OFFICE USE ONLY

Plan for Follow-up ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor
☐ Parent declined ☐ Already in treatment ☐ Referred to other professional

TS _____

Q 36 or Q 37=Y ◆ TS ≥ 30

PATIENT NAME: _____ DOB: _____ DATE OF SERVICE: _____

CARIES RISK ASSESSMENT QUESTIONNAIRE FOR CHILDREN

If there are NO teeth present in the child's mouth answer "no" to questions A through C.

VISUAL EXAMINATION: YES/NO

A.	Child has: one un-restored cavity	Y	N
	more than one un-restored cavity	Y	N
B.	Child has poor oral hygiene; visible plaque, gingivitis (redness or bleeding gums)	Y	N
C.	Child has enamel hypoplasia (white, chalky spots on teeth)	Y	N

HISTORY: YES /NO

A.	Mother or sibling has un-restored cavities	Y	N
B.	Lack of adequate fluoride exposure (family's drinking water source is a private well or the family's drinking water source is a public water supply that is not fluoridated and/or the child is not receiving fluoride supplements including fluoride contained in toothpaste)	Y	N
C.	Frequent (3 or more) between-meal exposures to snacks or foods containing simple sugars strongly associated with tooth decay such as carbonated beverages, juices, cookies, cakes, candy, French fries, potato chips, pretzels (If infant or child is nursed with a bottle, does the caretaker allow the infant or child to sleep or nap with a bottle containing juice, milk, or carbonated beverages)	Y	N
D.	Low socioeconomic status of parents (≤ 100% Federal Poverty Level)	Y	N
E.	Family does not have a Dental Home or seldom visits a dentist	Y	N
F.	Child has special health care needs because of a chronic physical, developmental, behavioral, or emotional condition	Y	N
G.	Child has condition(s) that impairs saliva flow (congenital or acquired: surgery, radiation, medication, or age-related changes in salivary function)	Y	N

SCORE (total number of ***yes*** answers): _____

This questionnaire is designed to help identify children at High Risk for dental decay. **If the total number of *"Yes"* answers is ≥ 5, the child is at High Risk and should be referred to a dentist for an oral evaluation and the establishment of a Dental Home.** A ***Dental Home*** is an ongoing relationship between a patient and a dentist where comprehensive dentistry is continuously accessible in a family-centered way.

Approved by TDAC September 2009

Risk Assessment Questionnaire

Patient's Name _____ **DOB** ____/____/____

Assessment Date ____/____/____

Lead (ages 6 – 72 months): Mandatory questions	Yes	No	Unsure
Does the child live in or regularly visit a house/apartment built before 1950? This could include a daycare center, home of a baby sitter, or a relative.)			
Does the child live in or regularly visit a house/apartment built before 1978 with recent or ongoing remodeling?			
Does the child have a sibling or a playmate that has, or did have lead poisoning?			

Lead (ages 6 – 72 months): Optional questions	Yes	No	Unsure
Does child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead or has a hobby which uses lead such as welding, construction, or pottery making?			
Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery, etc.)			
Have you ever been told that your child has low iron?			
Does your child live in or regularly visit a house(or daycare facility) built before 1960?			
Does your family use pottery ware or lead crystal for cooking, eating or drinking?			
Has child been seen eating paint chips, crayons, or soil/dirt?			
Is child given any home or folk remedies that may contain lead (may include moonshine Azarcon, Greta, Payloоah)?			
Does your home's plumbing have lead pipes or copper pipes with lead solder joints?			

Please note: Lead level laboratory tests are mandatory at 12 and 24 months.

Tuberculosis (Initiate @ one- year)	Yes	No	Unsure
Has child been in close contact with a person with infectious tuberculosis?			
Does child have HIV infection or considered at risk for HIV infection?			
Is child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?			
Is child in contact with the following individuals? HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers?			
Does child have a depressed immune system, either because of disease or treatment of disease?			
Does child live in an established "high risk for tuberculosis" community or area?			

Cholesterol (Initiate @ two- years)	Yes	No	Unsure
Does child have risk factors for future coronary disease such as physical inactivity, obesity, or Diabetes Mellitus?			
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease below age 55?			
Is there a family history (parents and grandparents) of elevated blood cholesterol?			