RISK ASSESSMENT QUESTIONNAIRE

LEAD RISK ASSESSMENT (For ages 6 months to 72)

1*	Does your child live in, or regularly visit, a house built before 1950? (day care center, baby sitter's home, relative's home)	Y	N
2*	Does your child live in or regularly visit a house built before 1978 that has recent, ongoing or planned renovations or remodeling? (within the past 6 months)	Y	N
3*	Does your child have a brother, sister, or playmate that has, or did have, lead poisoning?	Y	N
4	Does your child frequently come in contact with an adult who works with lead? (construction, welding, pottery, etc.)	Y	N
5	Does your home contain any plastic or vinyl mini blinds?	Y	N
6	Have you ever been told that your child has low iron?	Y	N
7	Have you ever seen your child eating paint chips, crayons, soil, or dirt?	Y	N
8	Does your child live near, or visit with someone who lives near, a lead smelter, battery recycling plant, or other industry that could release lead?	Y	N
9	Do you give your child any home or folk remedies that may contain lead? (such as moonshine, Azarcon, Greta, Payloon)	Y	N
10	Does your child live within 80 feet (or one block) of a heavily traveled road or heavily traveled street?	Y	N
11	Does your home's plumbing have lead pipes or copper pipes with lead solder joints?	Y	N
12	Does your family use pottery ware or lead crystal for cooking, eating, or drinking?	Y	N

* Mandatory questions, other 9 questions are optional based on professional judgment

CHOLESTEROL RISK ASSESSMENT (For ages 2 years and older)

1	Do the child's parents or grandparents have a history of heart disease, heart attack, or stroke before age 55?	Y	N
2	Do either of the child's parents have high cholesterol (over 240), or are they taking medication for high cholesterol?	Y	N

TUBERCULOSIS RISK ASSESSMENT

1	Are you or your child in close contact with a person with TB (tuberculosis)?	Y	N
2	Are you or your child, foreign born especially, (Asian, African, Latin American), a refugee or a migrant?	Y	N
3	Have you, your child, or any household member traveled to a country where TB is common (e.g., Africa, Asia, Latin America, Eastern Europe, Russia, Caribbean) in the last 12 months?	Y	N
4	Do you or your child have a medical condition or treatment of a medical condition which suppresses the immune system?	Y	N
5	Do you or your child have HIV infection or is he/she considered at risk for HIV infection?	Y	N
6	Are you or your child exposed to the following individuals: HIV infected, homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, or migrant farm workers.	Y	N

IMMUNIZATION RISK ASSESSMENT (For ALL children who are to receive an immunization)

1	Does your child or any household member have a medical condition, or treatment of a medical condition, which affects the immune system?	Y	N
2	Does your child have a moderate or severe illness with or without fever?	Y	N
3	Is your child allergic to any of the vaccine components?	Y	N
4	Has your child ever had a fever of 105° or greater within 48 hours following an immunization?	Y	N
5	Has your child ever had a convulsion after receiving an immunization?	Y	N
6	Has your child ever had limpness (collapse/shock like state) within 48 hours of receiving an immunization?	Y	N
7	Has your child ever had inconsolable crying (lasting > 3 hours) within 48 hours of receiving an immunization?	Y	N
8	Other:	Y	N

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

ASQ-3 Ages & Stages Questionnaires®

30 Month Questionnaire

28 months 16 days through 31 months 15 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child Information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's date of birth: _____

Child's gender:
◯ Male ◯ Female

Person Filling Out Questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____

P101300100

ASQ-3

30 Month Questionnaire

28 months 16 days through 31 months 15 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by ____________.

Notes:

____

____

____

____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. 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?	○	○	○	___
2. 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."
○ b. "Close the door."
○ c. "Bring me a towel."
○ d. "Find your coat."
○ e. "Take my hand."
○ f. "Get your book."

	YES	SOMETIMES	NOT YET	
3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least *seven* body parts? *(She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)*	○	○	○	___
4. Does your child make sentences that are three or four words long? Please give an example:	○	○	○	___

	YES	SOMETIMES	NOT YET	
5. Without giving your child help by pointing or using gestures, ask him to "put the book *on* the table" and "put the shoe *under* the chair." Does your child carry out both of these directions correctly?	○	○	○	___
6. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"	○	○	○	___

COMMUNICATION TOTAL ___

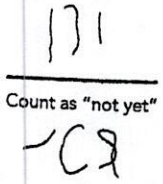
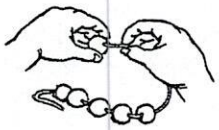
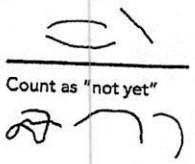
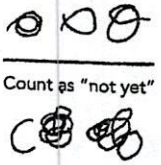
GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling?		○	○	○	___
2. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*		○	○	○	___
3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		○	○	○	___
4. Does your child jump with both feet leaving the floor at the same time?		○	○	○	___
5. Does your child walk up stairs, using only one foot on each stair? *(The left foot is on one step, and the right foot is on the next.)* She may hold onto the railing or wall.		○	○	○	___ *
6. Does your child stand on one foot for about 1 second without holding onto anything?		○	○	○	___

GROSS MOTOR TOTAL ___

**If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. 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?	○	○	○	___
2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction? Count as "yes" / Count as "not yet" 	○	○	○	___
3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	___
4. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction? Count as "yes" / Count as "not yet" 	○	○	○	___
5. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle? Count as "yes" / Count as "not yet" 	○	○	○	___
6. Does your child turn pages in a book, one page at a time?	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When looking in the mirror, ask, "Where is _____?" *(Use your child's name.)* Does your child point to her image in the mirror? 	○	○	○	___
2. If your child wants something he cannot reach, does he 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)?	○	○	○	___

PROBLEM SOLVING (continued)

YES | SOMETIMES | NOT YET

3. 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.)*

4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? *(Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")* Please write your child's response here:

5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same order? *Do not repeat the numbers.* If necessary, try another pair of numbers and say, "Say 'eight two.'" Your child must repeat just one series of two numbers for you to answer "yes" to this question.

6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? *(You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)*

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

YES | SOMETIMES | NOT YET

1. If you do any of the following gestures, does your child copy at least one of them?

   ○ a. Open and close your mouth. ○ c. Pull on your earlobe.

   ○ b. Blink your eyes. ○ d. Pat your cheek.

2. Does your child use a spoon to feed himself with little spilling?

3. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?

4. Does your child put on a coat, jacket, or shirt by himself?

5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?

6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other toddlers her age? If no, explain: ○ YES ○ NO

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Can other people understand most of what your child says? If no, explain: ○ YES ○ NO

5. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ○ YES ○ NO

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

7. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

8. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

9. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

10. Does anything about your child worry you? If yes, explain: ○ YES ○ NO