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, Paylooh)	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

Developmental Milestones Checklist *

Child's Name _____ **DOB** _____

12 Months

- ☐ Pulls to stand, cruises, and may take a few steps alone
- ☐ Plays pat-a-cake, peek-a-boo, or so-big
- ☐ Points
- ☐ Bangs blocks together
- ☐ Says 2-4 words, imitates vocalizations
- ☐ Drinks from cup
- ☐ Looks for dropped or hidden objects
- ☐ Waves "ye-bye"
- ☐ Feeds self

Date _____ Signature _____

15 Months

- ☐ Says 3-6 words
- ☐ Can point to a body part
- ☐ Understands simple commands
- ☐ Walks well
- ☐ Stoops
- ☐ Climbs stairs
- ☐ Stacks two blocks
- ☐ Feeds self with fingers
- ☐ Drinks from cup
- ☐ Listens to story
- ☐ Tells what he/she wants by pulling, pointing, or grunting

Date _____ Signature _____

18 Months

- ☐ Walks backward
- ☐ Throws ball
- ☐ Says 15 – 20 words
- ☐ Imitates words
- ☐ Uses two-word phrases
- ☐ Stacks three blocks
- ☐ Uses a spoon and cup
- ☐ Listens to a story, looking at pictures and naming objects
- ☐ Shows affection, kisses
- ☐ Follows simple directions
- ☐ Points to some body parts
- ☐ Scribbles
- ☐ Pulls a toy along the ground

Date _____ Signature _____

24 Months

- ☐ Goes up and down stairs one step at a time
- ☐ Kicks ball
- ☐ Stacks five blocks
- ☐ Uses at least 20 words, two-word phrases
- ☐ Follows two-step commands
- ☐ Imitates adults

Date _____ Signature _____

3 Years

- ☐ Jumps
- ☐ Kicks ball
- ☐ Rides tricycle
- ☐ Knows name, age, and sex
- ☐ Copies circle, cross

Date _____ Signature _____

Reference: Bright Futures

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

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

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

ASQ-3 Ages & Stages Questionnaires®

17 months 0 days through 18 months 30 days

18 Month Questionnaire

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

Date ASQ completed: _____

Child's information

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

Child's date of birth: _____

If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

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

Street address: _____

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

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 #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

P101180100

ASQ-3

18 Month Questionnaire

17 months 0 days through 18 months 30 days

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

Important Points to Remember:

- ☑ Try each activity with your child 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:

_____

_____

_____

_____

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by *pointing* to it?	○	○	○	___
2. When you ask your child to, does he go into another room to find a familiar toy or object? *(You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")*	○	○	○	___
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	○	○	○	___
4. 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.)*	○	○	○	___
5. 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?" *(He needs to identify only one picture correctly.)*	○	○	○	___
6. 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:	○	○	○	___

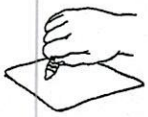
COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	○	○	○	___
2. Does your child move around by walking, rather than by crawling on her hands and knees?	○	○	○	___
3. Does your child walk well and seldom fall?	○	○	○	___
4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	___
5. 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.)*	○	○	○	___
6. 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.)* 	○	○	○	___

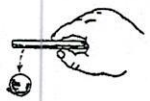
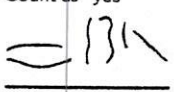
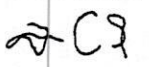
GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	○	○	○	___
2. Does your child stack a small block or toy on top of another one? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	___
3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw? 	○	○	○	___
4. Does your child stack three small blocks or toys on top of each other by himself?	○	○	○	___
5. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	○	○	○	___
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your child drop several small toys, one after another, into a container like a bowl or box? *(You may show him how to do it.)*	○	○	○	___
2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? 	○	○	○	___
3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? *(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)*	○	○	○	___
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	○	○	○	___
5. 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"  Count as "not yet" 	○	○	○	___
6. 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.)*	○	○	○	___ *

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While looking at herself in the mirror, does your child offer a toy to her own image?	○	○	○	___
2. Does your child play with a doll or stuffed animal by hugging it?	○	○	○	___
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	○	○	○	___
4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar?	○	○	○	___
5. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	___
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	○	○	○	___

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 his age? If no, explain: ○ YES ○ NO

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

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

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

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

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OVERALL *(continued)*

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

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

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