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

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

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

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