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

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 <u>usually</u> 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** <u>or</u> **no** for every question. Thank you very much.

Question		
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 <u>unusual</u> 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

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