

4 Year Well Child Check

Name: _____

Date: _____

Diet:

Does child get Calcium 1000mg/day and Vitamin D (600 IU/day)? _____

Dental:

Does child use fluoride toothpaste twice daily? _____

Has the child been to the dentist? _____ Recommend every 6 months

Have you had fluoride treatments done? _____

Elimination:

Does your child have regular stools? _____

Is your child toilet trained? _____

Does your child have any accidents? _____

Sleep:

Is your child getting 11-13 hours of sleep? _____

Does your child sleep through the night? _____

Does your child take naps? _____

Behavior/Temperament

Do you have any concerns?

Development:

Do you have any concerns about your child's development, behavior, or learning? yes no

If yes, please describe:

Children at 4 years almost all will (please circle yes or no)

- Get dressed with no help yes no
- Copy a circle yes no
- Knows 3 adjectives yes no
- Speech is 100% understandable yes no
- Count one block yes no
- Use of 3 objects yes no
- Knows 4 actions yes no
- Balance on each foot for 2 seconds yes no
- Draw a 3 part person yes no
- Can give first and last name yes no
- Engages in fantasy play yes no

Some children can

- Brush teeth with no help yes no
- Prepare cereal yes no
- Play board or card games yes no
- Pick longer line between the two yes no
- Hop yes no
- Know four or more colors yes no
- Balance on each foot for 3 seconds yes no

Social:

Any changes at home or new stressors? _____



Ages & Stages Questionnaires®

48 Month Questionnaire

45 months 0 days through 50 months 30 days



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 gender:
 Male Female

Child's date of birth: _____

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: _____



48 Month Questionnaire

45 months 0 days
through 50 months 30 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:

Notes:

- 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 _____.

COMMUNICATION

YES SOMETIMES NOT YET

1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?

2. Does your child answer the following questions? (Mark "sometimes" if your child answers only one question.)

"What do you do when you are hungry?" (Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.") Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.") Please write your child's response:




3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?

4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?

COMMUNICATION (continued)

	YES	SOMETIMES	NOT YET	
5. Without your giving help by pointing or repeating, does your child follow three directions that are <i>unrelated</i> to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I am going to the park," or "Is there a toy to play with?" or "Are you coming, too?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child catch a large ball with both hands? (You should stand about 5 feet away and give your child two or three tries before you mark the answer.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. While standing, does your child throw a ball <i>overhand</i> in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. (Dropping the ball or throwing the ball underhand should be scored as "not yet.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? (You may give your child two or three tries before you mark the answer.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
				GROSS MOTOR TOTAL _____

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child put together a five- to seven-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

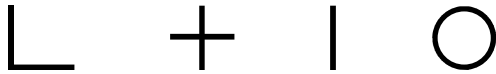
FINE MOTOR (continued)

2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.)



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? (Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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4. Does your child unbutton one or more buttons? (Your child may use his own clothing or a doll's clothing.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? (Your child should not go more than 1/4 inch outside the lines on most of the picture.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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FINE MOTOR TOTAL —

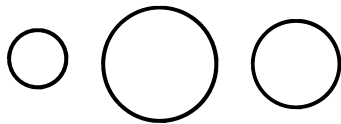
PROBLEM SOLVING

1. When you say, "Say 'five eight three,'" does your child repeat just the three numbers in the same order? Do not repeat the numbers. If necessary, try another series of numbers and say, "Say 'six nine two.'" (Your child must repeat just one series of three numbers to answer "yes" to this question.)

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? (Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "under" the couch. Then ask her to put the ball "between" the chairs and the book "in the middle" of the table.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? (Mark "yes" only if your child answers the question correctly using five colors.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? (Ask this question without providing help by pointing, gesturing, or naming.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| PROBLEM SOLVING TOTAL | | | | ___ |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child tell you at least four of the following? Please mark the items your child knows. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <input type="radio"/> a. First name <input type="radio"/> d. Last name
<input type="radio"/> b. Age <input type="radio"/> e. Boy or girl
<input type="radio"/> c. City she lives in <input type="radio"/> f. Telephone number | | | | |
| 3. Does your child wash his hands using soap and water and dry off with a towel without help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child tell you the names of two or more playmates, not including brothers and sisters? (Ask this question without providing help by suggesting names of playmates or friends.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? (You may still need to check and rebrush your child's teeth.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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

OVERALL (continued)

2. Do you think your child talks like other children 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 children 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

OVERALL (continued)

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



48 Month ASQ-3 Information Summary

45 months 0 days through
50 months 30 days

Child's name: _____ Date ASQ completed: _____
 Child's ID #: _____ Date of birth: _____
 Administering program/provider: _____

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	30.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	○	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|---|-----|-----------|---|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Family history of hearing impairment?
Comments: | YES | No |
| 2. Talks like other children his age?
Comments: | Yes | NO | 7. Concerns about vision?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Any medical problems?
Comments: | YES | No |
| 4. Others understand most of what your child says?
Comments: | Yes | NO | 9. Concerns about behavior?
Comments: | YES | No |
| 5. Walks, runs, and climbs like other children?
Comments: | Yes | NO | 10. Other concerns?
Comments: | YES | No |

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the area, it is above the cutoff, and the child's development appears to be on schedule.
 If the child's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
 If the child's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

Risk Indicators for Hearing Loss Checklist

(To be used with the **Developmental Scales** form when performing KBH screens for birth through four years of age.)

Child's name: _____ Birthdate: _____

What was your child's birth weight? _____ Premature? _____ By how many weeks? _____

Was the child's hearing screened as a newborn? Yes ____ No ____ Unknown ____

Results of the testing/screening: _____

Has your child's hearing been tested or screened since birth? Yes ____ No ____ Unknown ____

Results of the testing/screening: _____

Directions: Mark an X in the appropriate column. If an indicator exists but has been referred in a previous screening, note to whom the child was referred and note the follow-up recommendations.

{N = indicator for infants birth through 28 days old who *did not* have newborn hearing screening; for children older than 28 days, answer all questions.}

YES NO

____ ____ 1. Do you have a concern about your child's hearing, speech, language or other development delay?
List concerns: _____

____ ____ 2. **N** As a newborn, did your child have an illness/condition requiring 48 hours or more in the NICU?
Explain: _____

____ ____ 3. **N** Was your child exposed to any of the following during the mother's pregnancy? Check all that apply:
toxoplasmosis syphilis rubella cytomegalovirus herpes unknown

____ ____ 4. **N** Does your child have any abnormal features of the outer ear, ear canal, mouth, nose, neck or head?
Explain: _____

____ ____ 5. **N** Have any of your child's relatives had a permanent hearing loss before the age of 5?
Explain: _____

____ ____ 6. **N** Was your child diagnosed at birth as having a syndrome or condition known to include a sensorineural or conductive hearing loss or eustachian tube dysfunction?
Explain: _____

____ ____ 7. Has your child been diagnosed as having any syndromes associated with progressive hearing loss such as Down, Usher, Waardenburg; a neurodegenerative disorder such as Hunter syndrome; or sensory motor neuropathies such as Friedreich's ataxia or Charcot-Maire-Tooth Syndrome?
Explain: _____

____ ____ 8. Has your child had bacterial meningitis (or other postnatal infections) associated with hearing loss?
If yes, at what age? _____ Hearing testing since then? _____

____ ____ 9. Has child ever had any head trauma?
Explain: _____

____ ____ 10. As a newborn, did your child need an exchange transfusion because of hyperbilirubinemia, or have the need for mechanical ventilation, or conditions requiring ECMO?
Explain: _____

____ ____ 11. Has your child had otitis media with effusion that lasts for more than 3 months? Yes ____ No ____
If yes, were tubes placed? Yes ____ No ____ If yes, when? _____ Are they in place now? Yes ____ No ____

Note: The presence of any risk indicator denotes need for screening every six months up to three years of age or as otherwise indicated by an audiologist.

Pass = All "NO" responses. Refer = One or more "YES" response(s). **Check One: Pass** **Refer**

If other, explain: _____

Screener: _____ **Date:** _____

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE WHEN INDICATED.

Developmental Scales

(To be used with **Risk Indicators for Hearing Loss Checklist** when performing KBH screens for birth through four years of age.)

Name: _____ **Date of birth:** _____

Child's chronological age _____ Premature _____ months Adjusted age _____

Does your child: (Please check questions in the appropriate age category – **use adjusted age**)

Birth to 4 months	Yes	No	Yes	No
Startle or cry to loud noises?			Respond to a familiar voice?	
Awaken to loud sounds?			Stop crying when talked to?	
Stop moving when a new sound is made?				

4 to 8 months	Yes	No	Yes	No
Stir or awaken when sleeping quietly and someone talks or makes a loud noise?			Cry when exposed to a sudden or loud sound?	
Try to turn head toward an interesting sound or when name is called?			Make several different babbling sounds?	
Listen to a soft musical toy, bell, or rattle?				

8 to 12 months	Yes	No	Yes	No
Respond in some way to the direction "no"?			Stir or awaken when sleeping quietly and someone talks or makes a loud sound?	
React to name when called?			Try to imitate you if you make familiar sounds?	
Turn head toward the side where a sound is coming from?			Use variety of different consonants and vowels when babbling (cononical babbling*)?	

12 to 18 months	Yes	No	Yes	No
Say "mama" or "dada" and imitate many words you say?			Turn head to look in the direction where the sound came from when an interesting sound is presented?	
Respond to requests such as "come here" and "do you want more"?			Wake up when there is a loud sound?	

18 to 24 months	Yes	No	Yes	No
Try to sing?			Speak at least 20 words?	
Point to several different body parts?			Request by name items such as milk or cookies?	
Respond to simple commands such as "put the ball in the box"?				

2 to 5 years	Yes	No	Yes	No
Point to a picture if you say "Where's the _____"?			Listen to TV or radio at same loudness level as other family members?	
Talk in short sentences?			Hear you when you call child's name from another room?	
Notice most sounds?				

(*Cononical babbling is defined as nonrepetitive babbling using several consonant and vowel combinations, such as "itika," "dabata," "omada." It is quite different from common babbling such as "dada," "mama," or "baba.")

Pass = All "YES" responses or only one "NO" response. Refer = Two or more "NO" responses.

Check one: Pass Refer If other, explain: _____

Screener: _____ **Date:** _____

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE WHEN INDICATED.



KBH - EPSDT Blood Lead Screening Questionnaire

To be completed at each KBH screen from 6 to 72 months

Does your child: (circle response received)	DATE: (MM/DD/YYYY)						
1) Live in or visit a house or apartment built before 1960? This could include a day care center, preschool, or the home of a babysitter or relative.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
2) Live in or regularly visit a house or apartment built before 1960 with previous, ongoing, or planned renovation or remodeling?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
3) Have a family member with an elevated blood lead level?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
4) Interact with an adult whose job or hobby involves exposure to lead? Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
5) Live near a lead smelter, battery plant, or other lead industry? Ammunition/explosives, auto repair/auto body, cable/wiring striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
6) Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
One positive response to the above questions <u>requires</u> a blood lead level test. Remember blood lead levels tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Interviewing staff initials							

Staff signature

Patient name: _____

ID number: _____

Well Child Check Visual Acuity

Corrected: Yes / No

OD - Right eye: 20/____

OS - Left eye: 20/____

OU - Both eyes: 20/____

Patient is unable to complete visual acuity due to:

***Please remember to document in Cerner intake