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)

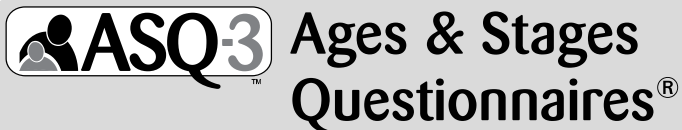
- Get dressed with no help yes no
- Copy a circle yes no
- Knows 3 adjectives yes no
- Speech is 100% understandable yes no
- Count one block yes no
- Use of 3 objects yes no
- Knows 4 actions yes no
- Balance on each foot for 2 seconds yes no
- Draw a 3 part person yes no
- Can give first and last name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

51 months 0 days through 56 months 30 days

54 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 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: ______________________

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54 Month Questionnaire *51 months 0 days through 56 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:

- ☑ 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. 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"?	○	○	○	___
2. 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," "*Is* there *a* toy to play with?" or "*Are* you coming, too?"	○	○	○	___
3. 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*s*," "I am play*ing*," or "I kick*ed* the ball"?	○	○	○	___
4. Without giving your child help by pointing or repeating directions, does he follow three directions that are *unrelated* 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."	○	○	○	___
5. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:	○	○	○	___
6. When talking about something that already happened, does your child use words that end in "-ed," such as "walk*ed*," "jump*ed*," or "play*ed*"? Ask your child questions, such as "How did you get to the store?" ("We walk*ed*.") "What did you do at your friend's house?" ("We play*ed*.") Please write an example:	○	○	○	___

COMMUNICATION TOTAL ___

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GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child hop up and down on either the right foot or the left foot at least one time without losing her balance or falling?	○	○	○	___
2. While standing, does your child throw a ball *overhand* 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.")*	○	○	○	___
3. Does your child jump forward a distance of 20 inches from a standing position, starting with her feet together?	○	○	○	___
4. 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.)*	○	○	○	___
5. 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.)*	○	○	○	___
6. Does your child walk on his tiptoes for 15 feet (about the length of a large car)? *(You may show him how to do this.)*	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. 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.)*	○	○	○	___
2. Does your child unbutton one or more buttons? Your child may use his own clothing or a doll's clothing.	○	○	○	___
3. 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.)*	○	○	○	___

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FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
4. Ask your child to trace on the line below with a pencil. Does your child trace on the line without going off the line more than two times? *(Mark "sometimes" if your child goes off the line three times.)*	○	○	○	___
5. Ask your child to draw a picture of a person on a blank sheet of paper. You may ask your child, "Draw a picture of a girl or a boy." If your child draws a person with head, body, arms, *and* legs, mark "yes." If your child draws a person with only three parts (head, body, arms, or legs), mark "sometimes." If your child draws a person with two or fewer parts (head, body, arms, or legs), mark "not yet." Be sure to include the sheet of paper with your child's drawing with this questionnaire.	○	○	○	___
6. Draw a line across a piece of paper. Using child-safe scissors, does your child cut the 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.)*	○	○	○	___
		FINE MOTOR TOTAL		___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. 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.)*	○	○	○	___
2. 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, sister, or an imaginary animal or figure.	○	○	○	___
3. If you place five objects in front of your child, can she count them by saying, "One, two, three, four, five" in order? *(Ask this question **without** providing help by pointing, gesturing, or naming.)*	○	○	○	___
4. When asked, "Which circle is smallest?" does your child point to the smallest circle? *(Ask this question **without** providing help by pointing, gesturing, or looking at the smallest circle.)*	○	○	○	___
5. Does your child count up to 15 without making mistakes? If so, mark "yes." If your child counts to 12 without making mistakes, mark "sometimes."	○	○	○	___

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PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. Does your child know the names of numbers? *(Mark "yes" if he identifies the three numbers below. Mark "sometimes" if he identifies two numbers.)*	○	○	○	___

3 1 2

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child wash her hands using soap and water and dry off with a towel without help?	○	○	○	___
2. 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.)*	○	○	○	___
3. Does your child brush his teeth by putting toothpaste on the toothbrush and brushing all of his teeth without help? *(You may still need to check and rebrush your child's teeth.)*	○	○	○	___
4. 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?)*	○	○	○	___
5. Does your child tell you at least four of the following? Please mark the items your child knows.	○	○	○	___

○ a. First name ○ d. Last name

○ b. Age ○ e. Boy or girl

○ c. City he lives in ○ f. Telephone number

	YES	SOMETIMES	NOT YET	
6. Does your child dress and undress herself, including buttoning medium-size buttons and zipping front zippers?	○	○	○	___

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

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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

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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

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54 Month ASQ-3 Information Summary

51 months 0 days through 56 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	31.85		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	35.18		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	17.32		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	28.12		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	32.33		●	●	●	●	●	●	●	○	○	○	○	○	○

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

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

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 ☐ (white) 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 ▒ (gray) area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ (black) 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						

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Revised 04.2016

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.

Excerpted from *Hearing Screening Guidelines and Resource Manual* (January 2004)

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.

Excerpted from *Hearing Screening Guidelines and Resource Manual* (January 2004)

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
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
3) **Have a family member with an elevated blood lead level?**		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
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
6) **Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?**		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
One positive response to the above questions requires 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
Interviewing staff initials							

Staff signature

Patient name: ______________________ **ID number:** ______________________

Revised 06.2016

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