

5 Year Well Child Check

Name: _____

Date: _____

Diet:

Does child eat breakfast everyday? _____

How much dairy does your child get? _____

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

Does your child get 5 plus servings of fruits and vegetables a day? _____

Does your child have a limit on sweet drinks, candy and high fat foods? _____

Dental:

Does child brush with 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? _____

Does your child have regular urination? _____

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 5 years almost all will (please circle yes or no)

- Prepare own cereal yes no
- Brush teeth with no help yes no
- Play a board or card game yes no
- Dress with no help yes no
- Pick longer line and copy a square yes no
- Draw 3-6 point person yes no
- Knows 3 adjectives yes no
- Define 5 words yes no
- Knows four or more colors yes no
- Balance on one foot for 4 seconds yes no

Some children can

- Know opposites yes no
- Balance on one foot for 5 seconds yes no
- Hop or skip yes no
- Count to 10 yes no
- Follow simple directions yes no
- Listen and attend yes no
- Heel to toe walk yes no

Social:

Any changes at home or new stressors? _____

Physical Activity:

Children should be provided opportunities for daily physical activity that is age and developmentally appropriate. Emphasis should be placed on play rather than structured exercise. Likewise, emphasize activities that engage the entire family to promote a culture of family activity. Aim for at least 60 minutes of physical activity and active play each day.



Ages & Stages Questionnaires®

60 Month Questionnaire

57 months 0 days through 66 months 0 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: _____



60 Month Questionnaire

57 months 0 days
through 66 months 0 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. Without your giving help by pointing or repeating directions, 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"/>	_____
2. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. When talking about something that already happened, does your child use words that end in "-ed," such as "walked," "jumped," or "played"? Ask your child questions, such as "How did you get to the store?" ("We walked.") "What did you do at your friend's house?" ("We played.") Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. Does your child use comparison words, such as "heavier," "stronger," or "shorter"? Ask your child questions, such as "A car is big, but a bus is _____" (bigger); "A cat is heavy, but a man is _____" (heavier); "A TV is small, but a book is _____" (smaller). Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION (continued)

5. 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:

6. Does your child repeat the sentences shown below back to you, without any mistakes? (Read the sentences one at a time. You may repeat each sentence one time. Mark "yes" if your child repeats both sentences without mistakes or "sometimes" if your child repeats one sentence without mistakes.)

Jane hides her shoes for Maria to find.
Al read the blue book under his bed.

COMMUNICATION TOTAL

GROSS MOTOR

1. 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.")



2. 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.)



3. 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.)



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

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------

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

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------


<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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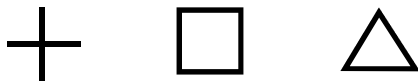
GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 4. Does your child walk on his tiptoes for 15 feet (about the length of a large car)? <i>(You may show him how to do this.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child hop forward on one foot for a distance of 4–6 feet without putting down the other foot? <i>(You may give him two tries on each foot. Mark "sometimes" if she can hop on one foot only.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child skip using alternating feet? <i>(You may show him how to do this.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

GROSS MOTOR TOTAL —

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. 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? <i>(Mark "sometimes" if your child goes off the line three times.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| <hr style="border: 1px solid black; width: 30%; margin: 10px auto;"/> | | | | |
| 2. 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, <i>and</i> 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. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. 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? <i>(Carefully watch your child's use of scissors for safety reasons.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
|  | | | | |
| 4. Using the shapes below to look at, does your child copy the shapes in the space below without tracing? <i>(Your child's drawings should look similar to the design of the shapes below, but they may be different in size. Mark "yes" if she copies all three shapes; mark "sometimes" if your child copies two shapes.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



(Space for child's shapes)

FINE MOTOR (continued)

5. Using the letters below to look at, does your child copy the letters without tracing? Cover up all of the letters except the letter being copied. (Mark "yes" if your child copies four of the letters and you can read them. Mark "sometimes" if your child copies two or three letters and you can read them.)

V H T C A

(Space for child's letters)

6. Print your child's first name. Can your child copy the letters? The letters may be large, backward, or reversed. (Mark "sometimes" if your child copies about half of the letters.)

(Space for adult's printing)

(Space for child's printing)

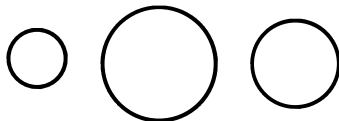
YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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

PROBLEM SOLVING

1. 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.)



2. 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.)

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

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------

PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 3. 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." | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child finish the following sentences using a word that means the opposite of the word that is italicized? For example: "A rock is <i>hard</i> , and a pillow is <i>soft</i> ." | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

Please write your child's responses below:

A cow is *big*, and a mouse is

Ice is *cold*, and fire is

We see stars at *night*, and we see the sun during the

When I throw the ball *up*, it comes

(Mark "yes" if he finishes three of four sentences correctly. Mark "sometimes" if he finishes two of four sentences correctly.)

- | | | | | |
|---|-----------------------|-----------------------|-----------------------|---|
| 5. Does your child know the names of numbers? (Mark "yes" if she identifies the three numbers below. Mark "sometimes" if she identifies two numbers.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
|---|-----------------------|-----------------------|-----------------------|---|

3 1 2

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|---|
| 6. Does your child name at least four letters in her name? Point to the letters and ask, "What letter is this?" (Point to the letters out of order.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
|--|-----------------------|-----------------------|-----------------------|---|

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Can your child serve himself, 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 wash her hands and face using soap and water and dry off with a towel without help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. 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 he lives in | <input type="radio"/> f. Telephone number |

PERSONAL-SOCIAL (continued)

	YES	SOMETIMES	NOT YET	
4. Does your child dress and undress himself, including buttoning medium-size buttons and zipping front zippers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child use the toilet by herself? <i>(She goes to the bathroom, sits on the toilet, wipes, and flushes.)</i> Mark "yes" even if she does this after you remind her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child usually take turns and share with other children?	<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

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

OVERALL (continued)

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

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



60 Month ASQ-3 Information Summary

57 months 0 days through
66 months 0 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	33.19		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	31.28		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	26.54		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.99		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	39.07		●	●	●	●	●	●	●	●	○	○	○	○	○

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						

Hearing Health History

For use with KBH screens for children 5 years of age and older.

Children who have had multiple ear infections and periods of hearing loss are more likely to have language, vocabulary, and listening difficulties. Some history is beneficial for a more complete evaluation. Parent(s) or guardian(s), please provide the following information.

Child's name: _____ Birthdate: _____

Primary care physician: _____

	Yes	No
1. Did your child have any ear problems* before the age of 1?	_____	_____
2. Has your child ever had a draining ear?	_____	_____
3. Approximately how many ear problems has your child had in his/her life? 0-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 10 or more <input type="checkbox"/>	_____	_____
4. Does your child tend to have 4 or more ear problems each year?	_____	_____
5. Has your child had an ear problem in the last 6 months?	_____	_____
6. Has your child ever had an ear problem that lasted 3 months or longer?	_____	_____
7. Has anyone related to the child had many ear problems?	_____	_____
8. Has your child ever been seen by an ear specialist? If yes, what doctor? _____ Month/year of last visit? _____	_____	_____
9. Has your child ever had tubes placed in his/her eardrum? If yes, how many times? _____ At what age(s)? _____ Which ear? _____	_____	_____
10. Are you concerned about your child's hearing?	_____	_____
11. Please mark all that apply to your child: chicken pox <input type="checkbox"/> head injury <input type="checkbox"/> meningitis <input type="checkbox"/> episode of high fever <input type="checkbox"/> other serious health condition such as cancer <input type="checkbox"/> Please describe the condition: _____ _____		

* Ear problem = ear infection, earaches, draining from ears, medicine taken for ears, fluid behind the eardrum, hole in eardrum, etc.

REFERRAL IS REQUIRED IF A CHILD ANSWERS YES TO ANY ONE INDICATOR ON AN INITIAL HEARING PAPER SCREEN.

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