MEDICAL RECORDS COPY

Health Maintenance Visit

4 YR - 5 YR

Patient Name _____ **MR#** _____

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO DOUBLE LINE (please circle)

NUTRITION (Subjective)

1. PARENT: HOW MANY SERVINGS OF EACH OF THE 4 FOOD GROUPS DOES YOUR CHILD EAT EACH DAY?
(Please write number of servings in space provided after reviewing **examples** of serving size for this age group.)

MILK	MEAT	FRUITS & VEGETABLES	GRAINS
3/4 cup milk	1/2 sm. hamburger	1/4 cup cooked fruit or vegetable	3/4 - 1 slice bread
3/4 cup yogurt	1/4 cup tuna	1/2 cup raw fruit or vegetable	1 cup cold cereal
3/4 cup ice cream	1 drumstick	1/2 cup juice	1/2 cup hot cereal
2/3 cup cottage cheese	1 egg		4 graham crackers
1 oz cheese	1 slice meat		1/4 cup rice, potatoes or noodles
	3 Tbsp. nuts, sunflower seeds or peanut butter		
_____ # of servings my child eats each day	_____ # of servings my child eats each day	_____ # of servings my child eats each day	_____ # of servings my child eats each day

2. List snack foods _____
3. Does your child having any problems with eating? ..... NO YES

ELIMINATION

4. Does your child have problems with urination, diarrhea, constipation, wetting or soiled pants? ..... NO Y'

BEHAVIOR

5. Does your child brush his teeth with fluoride toothpaste? ..... YES NO
6. Does your child have any problems with sleeping? ..... NO YES
7. Your child sleeps from _____ pm to _____ am
8. Does your child have any behaviors you would like to change? ..... NO YES
9. What do you do when your child doesn't mind? _____
10. Does your child play with other children his/her age? ..... YES NO
11. Does your child get along with them? ..... YES NO

DEVELOPMENT

12. Does your child pay attention when you read him a story? ..... YES NO
13. Can your child play quietly by himself for over 1/2 hour? ..... YES NO
14. Does your child mind adults and follow instructions? ..... YES NO
15. Does your child speak clearly enough for others to understand? ..... YES NO
16. Does your child object to being left with a sitter? ..... NO YES
17. Can your child dress himself without supervision? ..... YES NO
18. Can your child hop on one foot? ..... YES NO
19. Can your child throw a ball well? ..... YES NO
20. Does your child draw and color or paint pictures? ..... YES NO

ILLNESSES

21. If your child is on any medicines, name them: _____
22. Has your child had any serious illnesses or accidents since the last check-up? ..... NO Y'

REVIEW OF SYSTEMS (Check if your child has any of the following since the last visit.)

- ___ Headaches
- ___ Head injury or unconsciousness
- ___ Convulsion or seizures
- ___ Ear infections or earaches
- ___ Hearing problems
- ___ Crossed eyes/vision problems
- ___ Persistent nosebleeds
- ___ Frequent nasal congestion
- ___ Strep sore throats
- ___ Teeth problems
- ___ Bleeding/sore gums
- ___ Thumbsucking
- ___ Speech problems
- ___ Swollen glands
- ___ Wheezing or trouble breathing
- ___ Cannot keep up with friends when playing
- ___ Stomach pains
- ___ Frequent colds or coughing
- ___ Stomach pains
- ___ Anemia
- ___ Broken bones or sprains
- ___ Swollen or painful joints/limping
- ___ Loses balance
- ___ Allergies
- ___ Skin rashes or other problems
- ___ Depression
- ___ Recent weight gain or loss
- ___ Recent change in home/family
- ___ Accidents/injuries

OBJECTIVE:

NURSING DIAGNOSIS:

PLAN: (Anticipatory guidance checklist on page 1)

SIGNATURE _____

ASQ-3 Ages & Stages Questionnaires®

45 months 0 days through 50 months 30 days

48 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: _____

ASQ-3

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:

- ☑ 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 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 *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."	○	○	○	___
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?"	○	○	○	___
		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.)* 	○	○	○	___
2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?	○	○	○	___
3. 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.")* 	○	○	○	___
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?	○	○	○	___
5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?	○	○	○	___
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.)* 	○	○	○	___
		GROSS MOTOR TOTAL		___

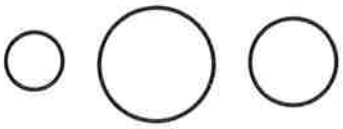
FINE MOTOR

	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?)*	○	○	○	___

FINE MOTOR (continued)

	YES	SOMETIMES	NOT YET	
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.)* 	○	○	○	—
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.)* 	○	○	○	—
4. Does your child unbutton one or more buttons? *(Your child may use his own clothing or a doll's clothing.)*	○	○	○	—
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?	○	○	○	—
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.)*	○	○	○	—
			FINE MOTOR TOTAL	—

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
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.)*	○	○	○	—
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.)* 	○	○	○	—
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."	○	○	○	—
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.)*	○	○	○	—

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.	○	○	○	___
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.)*	○	○	○	___

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?	○	○	○	___
2. Does your child tell you at least four of the following? Please mark the items your child knows.	○	○	○	___

- ○ a. First name
- ○ b. Age
- ○ c. City she lives in
- ○ d. Last name
- ○ e. Boy or girl
- ○ f. Telephone number

3. Does your child wash his hands using soap and water and dry off with a towel without help?	○	○	○	___
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.)*	○	○	○	___
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.)*	○	○	○	___
6. Does your child dress or undress himself without help (except for snaps, buttons, and 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

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? 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 ☐ 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						

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