

CASTLE VALLEY CHILDRENS' CLINIC

Health Maintenance Visit

2 Year - 3 Year

Patient Name _____

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO THE DOUBLE LINE (please circle and check appropriate answers)

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 review examples of serving size for this age group.

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

2. List snack foods _____

3. Are there table foods your child will not eat? yes no
4. How many glasses of each does your child drink each day? milk _____ water _____ yes no
5. Does your child use a spoon and cup? yes no
6. Does your child have any problems with eating? yes no
7. Is your child on WIC or Denver Food Supplemental Program? yes no
8. Do you brush your child's teeth everyday with a fluoride toothpaste? yes no

ELIMINATION

9. Does your child have pain with urination, frequent urination, weak or dribbling stream, strong or funny smell of urine? yes no
10. Does your child experience constipation, diarrhea, worms itching around rectum, or bleeding from bowels? yes no

BEHAVIOR

11. Does your child have any problems with sleeping? yes no
12. Your child sleeps from _____ pm to _____ am Number of naps _____
13. Does your child have any behaviors you would like to change? yes no
14. What do you do when your child doesn't mind? _____
15. Does your child spend time with other children? yes no

DEVELOPMENT

16. All children learn things at different times. At this point in your child's development, check which of the following he/she can do.

- | | | |
|------------------------------------|---|--------------------------|
| _____ Walk downstairs without help | _____ Pedal a tricycle | _____ Kick a ball |
| _____ Throw a ball overhead | _____ Wash his/her own hands | _____ Color and scribble |
| _____ Build a tower of four blocks | _____ Follow directions such as "give me" | _____ Put on clothing |

17. I feel my child's development is: NORMAL _____ ABNORMAL _____

ILLNESS

18. If your child is on any medications, name them: _____
19. Has your child had any serious illnesses or needed to see a doctor since the last checkup? yes no

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

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

OBJECTIVE:

NURSING DIAGNOSIS:

PLAN: (Anticipatory guidance checklist on page 1)

PROVIDER SIGNATURE _____



Ages & Stages Questionnaires®

36 Month Questionnaire

34 months 16 days through 38 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: _____



36 Month Questionnaire

34 months 16 days
through 38 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. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least seven body parts? (<i>She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child make sentences that are three or four words long? Please give an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Without giving your child help by pointing or using gestures, ask him to "put the book <i>on</i> the table" and "put the shoe <i>under</i> the chair." Does your child carry out both of these directions correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle and ask your child to move the zipper <i>down</i> . Return the zipper to the middle and ask your child to move the zipper <i>up</i> . Do this several times, placing the zipper in the middle before asking your child to move it up or down. Does your child consistently move the zipper up when you say "up" and down when you say "down"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you ask, "What is your name?" does your child say both her first and last names?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
COMMUNICATION TOTAL				—

GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child jump with both feet leaving the floor at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child stand on one foot for about 1 second without holding onto anything?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. While standing, does your child throw a ball overhand by raising his arm to shoulder height and throwing 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"/>	—
6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
					GROSS MOTOR TOTAL —

FINE MOTOR

		YES	SOMETIMES	NOT YET	
1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?	<p>Count as "yes"</p>  <p>Count as "not yet"</p> 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

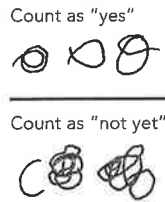
FINE MOTOR (continued)

2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?



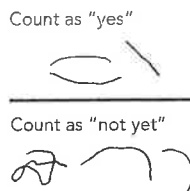
YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

3. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
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4. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
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5. Does your child try to cut paper with child-safe scissors? He does not need to cut the paper but must get the blades to open and close while holding the paper with the other hand. (You may show your child how to use scissors. Carefully watch your child's use of scissors for safety reasons.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
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6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?

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

PROBLEM SOLVING

1. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? (You can also use spools of thread, small boxes, or other toys.)



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

2. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?

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

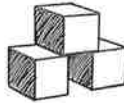
YES SOMETIMES NOT YET

3. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:



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

5. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it?



6. 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 for you to answer "yes" to this question.*)

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

YES SOMETIMES NOT YET

1. Does your child use a spoon to feed herself with little spilling?
2. Does your child push a little wagon, stroller, or toy on wheels, steering it around objects and backing out of corners if he cannot turn?
3. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?
4. Does your child put on a coat, jacket, or shirt by himself?
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?
6. Does your child take turns by waiting while another child or adult takes a turn?

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

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

OVERALL (continued)

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



36 Month ASQ-3 Information Summary

34 months 16 days through
38 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	30.99		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.99		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	18.07		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	30.29		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	35.33		●	●	●	●	●	●	●	○	○	○	○	○	○

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						