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

ASQ-3 42 Month ASQ-3 Information Summary

39 months 0 days through 44 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	27.06		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	36.27		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	19.82		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	28.11		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	31.12		●	●	●	●	●	●	●	○	○	○	○	○	○

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						

P101420800

PEDIATRIC VISIT 3 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/____% HEIGHT_____/____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	CHOL	TB	LEAD
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No_____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/ Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Education: Offer variety of nutritious foods/snacks ☐ May be picky ☐
Eats same foods as family ☐ 5 fruits/vegetables daily ☐
No sweetened beverages ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Dresses self ☐ Separates easily ☐ Plays interactive games ☐

Fine Motor: Copies: O _____ + _____ ☐ _____

Language: Understands 2of 3: cold, tired, hungry ☐
Understands 3 of 4 prepositions (block is on, under, behind in front of table) ☐ Speech clear to examiner ☐ Recognizes 3-4 colors ☐
Uses plurals ☐ Gives first and last name ☐ Knows sex (boy/girl) ☐

Gross Motor: Balances on 1 foot for 1 second ☐ Jumps well ☐
Broad jump ☐ Pedals tricycle ☐

ANTICIPATORY GUIDANCE:

Social: Needs peer contact ☐ Caution with strangers/animals ☐ Sibling rivalry ☐ Develops pride with accomplishments ☐
Caution with strangers/animals ☐

Parenting: Time out for serious misbehavior ☐ Read parenting books ☐
Help child to release energy ☐ Avoid smacking, spanking ☐
Encourage talk about feelings (instead of misbehaving) ☐
Dependency needs alternate with independence ☐
Special times alone with child ☐ Praise child ☐

Play and communication: Excursions, outdoor play, art ☐ Library ☐
Read to child ☐ Make up stories together ☐ Screen TV shows ☐

Health: Dental care ☐ Fears ☐ Physical activity ☐
Begin sex education (boy/girl differences, "private parts", etc) ☐
Masturbation ☐ Fluoride if well water ☐ Tick prevention ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Rear riding car seat ☐ Bicycle helmets ☐ Matches ☐
Riding toys in traffic ☐ Smoke detector/escape plan ☐
Poisoning (Plants, drugs, chemicals) ☐ Poison control # ☐
Hot water 120° ☐ Choking/suffocation ☐ Fall prevention (heights) ☐
Firearms (owner risk/safe storage) ☐ Water safety (tub, pool) ☐
Toddler proof home ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD, if positive risk assessment ☐_____
4. Testing/counseling, if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at 4 Years ☐_____
7. Referrals for identified problems:*(specify)*_____

_____

Signatures:_____

Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Child's Name: _____ **Date of Birth:** _____
Managed Care Organization: _____ **Child's Medicaid #:** _____

Ages 3 – 5 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child often wet or soil his pants? ☐ Yes ☐ No

Does your child have problems at day care or school? ☐ Yes ☐ No

Do you have any concerns about your child:
- Daydreaming? ☐ Yes ☐ No
- Paying attention? ☐ Yes ☐ No
- Sitting still? ☐ Yes ☐ No

Does your child:
- Refuse to obey? ☐ Yes ☐ No
- Refuse to play with others? ☐ Yes ☐ No

Does your child get tired easily? ☐ Yes ☐ No

Does your child often seem:
- Sad? ☐ Yes ☐ No
- Angry? ☐ Yes ☐ No
- Nervous or afraid? ☐ Yes ☐ No
- Cranky? ☐ Yes ☐ No
- Not interested? ☐ Yes ☐ No

Does your child have trouble sleeping? ☐ Yes ☐ No

Does your child have problems with eating? ☐ Yes ☐ No

Is your child often mean to animals or smaller children? ☐ Yes ☐ No

Is there a history of injuries, accidents? ☐ Yes ☐ No
If yes, please specify: _____

Continued on Back →

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Page Two

Is there any history of maltreatment or abuse? ..... ☐ Yes ☐ No

If yes, please specify: _____

Is there a recent stress on the family or child such as:

Birth of a child? ..... ☐ Yes ☐ No

Moving? ..... ☐ Yes ☐ No

Divorce or separation? ..... ☐ Yes ☐ No

Death of a close relative? ..... ☐ Yes ☐ No

Fired or laid off? ..... ☐ Yes ☐ No

Legal problems? ..... ☐ Yes ☐ No

Others (Please specify): _____

Do you have other parenting concerns? ..... ☐ Yes ☐ No

Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____

Provider's Signature Date

Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **MD Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

_____