



FAMILY HEALTH

A S S O C I A T E S

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PEDIATRIC HEALTH MAINTENANCE – 5 YEARS PATIENT QUESTIONNAIRE

General

Do you have any concerns about your child? Yes___ No___

If “yes,” please specify:

Is your child in daycare, preschool, or kindergarten? Yes___ No___

Do you have any concerns about your child’s vision or hearing? Yes___ No___

Do your child’s eyes ever appear to cross or drift apart? Yes___ No___

Does your child watch TV or use the computer for over 1 hour a day? Yes___ No___

Feeding and Sleeping

What type of milk does your child drink? Whole 1 or 2% Skim Other: ___

How much milk does your child drink each day? _____

Does your child eat a good variety of foods? Yes___ No___

Are you concerned about your child’s weight or eating habits? Yes___ No___

Does your child have daytime accidents? Yes___ No___

Is your child wet the bed? Yes___ No___

Environment

Who lives with you in your home? _____

Do you have pets? Yes___ No___

Does anyone smoke in your house? Yes___ No___

How are you preparing your child for school? _____

Safety

Does your child know how to get out of your house during a fire? Yes___ No___

Does your child wear a helmet when riding a bike, scooter, etc.? Yes___ No___

Are any guns in your home securely stored? Yes___ No___

Do you have a pool? Yes___ No___

Does your child ride in a car or booster seat in the back seat? Yes___ No___

Are you afraid of your partner or anyone close to you? Yes___ No___

Do you feel overly stressed or unsupported? Yes___ No___

Patient Name: _____

Completed by (name and relationship to patient): _____ Date: _____



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 children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

Notes:

- Try each activity with your child 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. 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"/>	_____
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				
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"/>	_____
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				
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"/>	_____
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				

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"/>	_____
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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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<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 her 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)

YES SOMETIMES NOT YET _____

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)

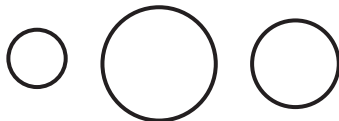
(Space for child's printing)

FINE MOTOR TOTAL _____

PROBLEM SOLVING

YES SOMETIMES NOT YET _____

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.)

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						



Well Child: 5 Years

Name: _____ Date: _____ Length: _____ in. (_____ %)

Weight: _____ lbs. _____ oz. (_____ %) Head Circumference: _____ cm. (_____ %)

IMMUNIZATIONS: Varicella, DTaP, MMR, Polio (if not yet received)

IBUPROFEN (Advil, Motrin) & ACETAMINOPHEN (Tylenol) DOSAGE

Child's Weight	Ibuprofen Infant Dose (50 mg/1.25mL)	Acetaminophen Infant's Suspension (160mg/5mL)
18-23lbs	1.87mL	3.75mL
24-35lbs	1.25mL + 1.25mL	5mL
36-47lbs	1.25mL + 1.25mL	7.5mL
48-59lbs	5mL	10mL

Ibuprofen may be given every 6 hours, but not more than 4 times in 24 hours. CHECK THE CONCENTRATION OF THE IBUPROFEN YOU ARE USING

Acetaminophen may be given every 4 hours, but not more than four times in 24 hours. Please call the office if fever persists for more than 2 days or if you have any questions.

NEXT VISIT: 6 Years

<u>How Your Family is Doing</u>	<u>Ready for School</u>
<ul style="list-style-type: none"> ▪ Spend time with your child. Hug and praise them. ▪ Help your child do things for themselves. ▪ Help your child deal with conflict. ▪ If you are worried about your living or food situation, talk with us. Community agencies and programs such as SNAP can also provide information and assistance. ▪ Don't smoke or use e-cigarettes. Keep your home and car smoke-free. Tobacco-free spaces keep children healthy. ▪ Don't use alcohol or drugs. If you're worried about a family member's use, let us know, or reach out to local or online resources that can help. 	<ul style="list-style-type: none"> ▪ Talk to your child about school. ▪ Read books with your child about starting school. ▪ Take your child to see the school and meet the teacher. ▪ Help your child get ready to learn. Feed them a healthy breakfast and give them regular bedtimes so they get at least 10 to 11 hours of sleep. ▪ Make sure your child goes to a safe place after school. ▪ If your child has disabilities or special health care needs, be active in the Individualized Education Program process.
<u>Family Rules and Routines</u>	
<ul style="list-style-type: none"> ▪ Family routines create a sense of safety and security for your child. ▪ Teach your child what is right and what is wrong. ▪ Give your child chores to do and expect them to be done. ▪ Use discipline to teach, not to punish. ▪ Help your child deal with anger. Be a role model. ▪ Teach your child to walk away when they are angry and do something else to calm down, such as playing or reading. 	

Safety

- Use a forward-facing car safety seat or switch to a belt-positioning booster seat when your child reaches the weight or height limit for their car safety seat, their shoulders are above the top harness slots, or their ears come to the top of the car safety seat.
- The back seat is the safest place for children to ride until they are 13 years old.
- Make sure your child learns to swim and always wears a life jacket. Be sure swimming pools are fenced.
- When you go out, put a hat on your child, have them wear sun protection clothing, and apply sunscreen with SPF of 15 or higher on their exposed skin. Limit time outside when the sun is strongest (11:00 am–3:00 pm).
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately.
- Ask if there are guns in homes where your child plays. If so, make sure they are stored safely
- **IF YOUR CHILD INGESTS POISON, CALL THE POISON CONTROL CENTER IMMEDIATELY AT 1(800)222-1222**

Getting Along With Others

- Help your child brush their teeth twice a day.
- Use a pea-sized amount of toothpaste with fluoride.
- Help your child floss their teeth once a day.
- Your child should visit the dentist at least twice a year.
- Help your child be a healthy eater by
 - Providing healthy foods, such as vegetables, fruits, lean protein, and whole grains
 - Eating together as a family
 - Being a role model in what you eat
- Buy fat-free milk and low-fat dairy foods. Encourage 2 to 3 servings each day.
- Limit candy, soft drinks, juice, and sugary foods.
- Make sure your child is active for 1 hour or more daily.
- Don't put a TV in your child's bedroom.
- Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.