PATIENT NAME_____**DATE OF BIRTH**_____

VISION RISK ASSESSMENT BIRTH TO 3 YEARS

1. Does your infant or child wear eye glasses? Y N
2. If so, when was their last eye exam? _____
3. Does your child seem to see well? Y N
4. Does your child hold objects close to their face when trying to focus? Y N
5. Do your child's eyes appear unusual or seem to cross, drift or be lazy? Y N
6. Do your child's eyelids droop or does one eyelid tend to close? Y N
7. Have your child's eyes ever been injured? Y N

(PHYSICIAN USE ONLY)

COMMENTS: NO SCREENING NEEDED

REFER TO OPTHAMOLOGY

Eye Consultants of Atlanta
Scottish Rite 404-255-2419
Marietta 770-424-5669

Cartersville Pediatric Associates
958A Joe Frank Harris Pkwy
Cartersville, GA 30120

Provider Signature:_____

LEAD RISK ASSESSMENT QUESTIONNAIRE

Please check "Yes" or "No" for the following questions:

	YES	NO
1. Does your child live in a house/apartment that was built before 1960?	☐	☐
2. Does your child live in a house/apartment that was built before 1978, that is being remodeled at this time?	☐	☐
3. Does anyone living with your child ever had elevated lead levels?	☐	☐
4. Does anyone living with your child work in a lead industry (radiator shop or battery manufacturer) or have a hobby that uses lead (welder, painter, etc.)?	☐	☐
5. Does your child eat paint chips or any non-food items or play in dirt where cars have been parked?	☐	☐
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?	☐	☐
7. Are home remedies such as greta, azarcon, or pay-loo-ah, or cosmetics with kohl in them used in your home?	☐	☐
8. Does anyone in the family use cosmetics, ethnic or folk remedies, or eat candy from Mexico?	☐	☐
9. Is your child a recent immigrant, refugee, or a member of a minority group?	☐	☐

COMMENTS: If there is an answer to YES or UNKNOWN to any of the questions above.

Patient Name: _____

Date of Birth: _____

Age: _____

Provider's Signature: _____ Today's Date: _____

CARTERSVILLE PEDIATRIC ASSOCIATES

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By **Diane Bricker** and **Jane Squires**
with assistance from ***Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly,*** *and* ***Jane Farrell***

9 Month Questionnaire

On the following pages are questions about activities children 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 check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Be sure to try each activity with your child before checking a box.
- ☑ Try to make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested, fed, and ready to play.
- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Look forward to filling out another questionnaire in _____ months.

ASQ™

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By **Diane Bricker** and **Jane Squires**
with assistance from ***Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly,*** *and* ***Jane Farrell***

9 Month Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

_____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ™

	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. If you call to your baby when you are out of sight, does he look in the direction of your voice?	❑	❑	❑	____
2. When a loud noise occurs, does your baby turn to see where the sound came from?	❑	❑	❑	____
3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	❑	❑	❑	____
4. Does your baby make sounds like "da," "ga," "ka," and "ba"?	❑	❑	❑	____
5. Does your baby respond to the tone of your voice and stop her activity at least briefly when you say "no-no" to her?	❑	❑	❑	____
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (He may say these sounds without referring to any particular object or person.)	❑	❑	❑	____
		COMMUNICATION TOTAL		____

GROSS MOTOR *Be sure to try each activity with your child.*

1. When you put her on the floor, does your baby lean on her hands while sitting? (If she already sits up straight without leaning on her hands, check "yes" for this item.)

❑ ❑ ❑ ____

2. Does your baby roll from his back to his tummy, getting both arms out from under him? ❑ ❑ ❑ ____

3. Does your baby get into a crawling position by getting up on her hands and knees?

❑ ❑ ❑ ____

4. If you hold both hands just to balance him, does your baby support his own weight while standing?

❑ ❑ ❑ ____

5. When sitting on the floor, does your baby sit up straight for several minutes *without* using her hands for support?

❑ ❑ ❑ ____*

6. When you stand him next to furniture or the crib rail, does your baby hold on without leaning his chest against the furniture for support?

❑ ❑ ❑ ____

GROSS MOTOR TOTAL ____

**If gross motor item 5 is marked "yes" or "sometimes," mark gross motor item 1 as "yes."*

	YES	SOMETIMES	NOT YET	

FINE MOTOR *Be sure to try each activity with your child.*

1. Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? (If she already picks up a small object, check "yes" for this item.)

❑ ❑ ❑ ____

2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?

❑ ❑ ❑ ____

3. Does your baby *try* to pick up a crumb or Cheerio by using her thumb and all her fingers in a raking motion, even if she isn't able to pick it up? (If she already picks up a crumb or Cheerio, check "yes" for this item.)

❑ ❑ ❑ ____

4. Does your baby pick up small toys with only one hand?

❑ ❑ ❑ ____

5. Does your baby *successfully* pick up a crumb or Cheerio by using his thumb and all his fingers in a raking motion? (If he already picks up a crumb or Cheerio, check "yes" for this item.)

❑ ❑ ❑ ____

6. Does your baby pick up a small toy with the *tips* of her thumb and fingers? (You should see a space between the toy and her palm.)

❑ ❑ ❑ ____*

FINE MOTOR TOTAL ____

**If fine motor item 6 is marked "yes" or "sometimes," mark fine motor item 2 as "yes."*

PROBLEM SOLVING *Be sure to try each activity with your child.*

1. Does your baby pick up a toy and put it in his mouth?

❑ ❑ ❑ ____

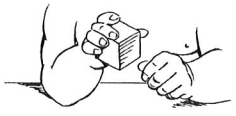
2. When she is on her back, does your baby try to get a toy she has dropped if she can see it?

❑ ❑ ❑ ____

3. Does your baby play by banging a toy up and down on the floor or table?

❑ ❑ ❑ ____

4. Does your baby pass a toy back and forth from one hand to the other?



❑ ❑ ❑ ____

YES SOMETIMES NOT YET

PROBLEM SOLVING *(continued)*

5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?

❑ ❑ ❑ ___

6. When holding a toy in his hand, does your baby bang it against another toy on the table?

❑ ❑ ❑ ___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. While lying on her back, does your baby play by grabbing her foot?

❑ ❑ ❑ ___

2. When in front of a large mirror, does your baby reach out to pat the mirror?

❑ ❑ ❑ ___

3. Does your baby try to get a toy that is out of reach? (He may roll, pivot on his tummy, or crawl to get it.) ❑ ❑ ❑ ___

4. While on her back, does your baby put her foot in her mouth?

❑ ❑ ❑ ___

5. Does your baby drink water, juice, or formula from a cup while you hold it? ❑ ❑ ❑ ___

6. Does your baby feed himself a cracker or a cookie? ❑ ❑ ❑ ___

PERSONAL-SOCIAL TOTAL ___

OVERALL *Parents and providers may use the bottom of the next sheet for additional comments.*

1. Do you think your child hears well? YES ❑ NO ❑

   If no, explain: _____

2. Does your baby use both hands equally well? YES ❑ NO ❑

   If no, explain: _____

3. When you help your baby stand, are her feet flat on the surface most of the time? YES ❑ NO ❑

   If no, explain: _____

OVERALL *(continued)*

4. Does either parent have a family history of childhood deafness or hearing impairment? YES ❑ NO ❑

   If yes, explain: _____

5. Do you have concerns about your child's vision? YES ❑ NO ❑

   If yes, explain: _____

6. Has your child had any medical problems in the last several months? YES ❑ NO ❑

   If yes, explain: _____

7. Does anything about your child worry you? YES ❑ NO ❑

   If yes, explain: _____

9 Month ASQ Information Summary

Child's name: _____ Date of birth: _____

Person filling out the ASQ: _____ Corrected date of birth: _____

Mailing address: _____ Relationship to child: _____

Telephone: _____ City: _____ State: _____ ZIP: _____

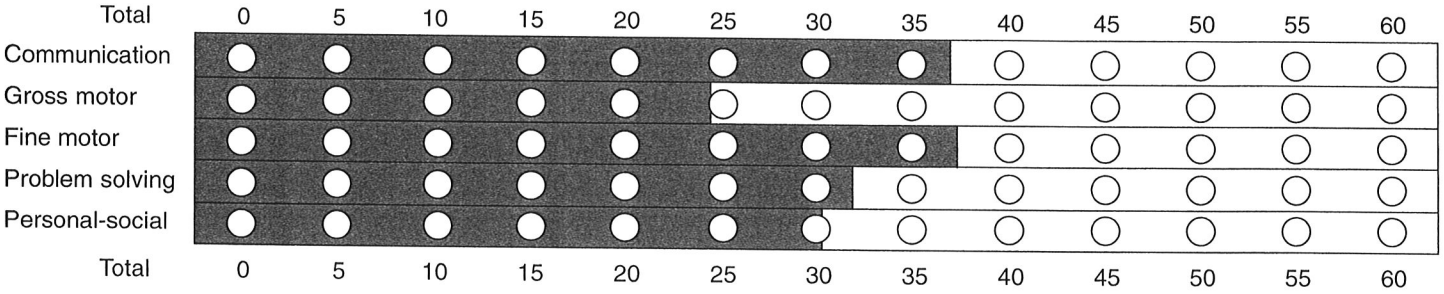
Today's date: _____ Assisting in ASQ completion: _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1. Hears well? YES NO
   Comments:
2. Uses both hands equally well? YES NO
   Comments:
3. Baby's feet flat on the surface? YES NO
   Comments:
4. Family history of hearing impairment? YES NO
   Comments:
5. Vision concerns? YES NO
   Comments:
6. Recent medical problems? YES NO
   Comments:
7. Other concerns? YES NO
   Comments:

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide.*
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the ▭ area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the ▬ area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

8 months

	Score	Cutoff
Communication		36.7
Gross motor		24.3
Fine motor		36.8
Problem solving		32.3
Personal-social		30.5

Communication	Gross motor	Fine motor	Problem solving	Personal-social
1 ○ ○ ○	1 ○ ○ ○	1 ○ ○ ○	1 ○ ○ ○	1 ○ ○ ○
2 ○ ○ ○	2 ○ ○ ○	2 ○ ○ ○	2 ○ ○ ○	2 ○ ○ ○
3 ○ ○ ○	3 ○ ○ ○	3 ○ ○ ○	3 ○ ○ ○	3 ○ ○ ○
4 ○ ○ ○	4 ○ ○ ○	4 ○ ○ ○	4 ○ ○ ○	4 ○ ○ ○
5 ○ ○ ○	5 ○ ○ ○	5 ○ ○ ○	5 ○ ○ ○	5 ○ ○ ○
6 ○ ○ ○	6 ○ ○ ○	6 ○ ○ ○	6 ○ ○ ○	6 ○ ○ ○
Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____