

(18mth)

Child's Name: _____ Date of birth: _____
Date Form Completed: _____ Name of Person Completing Form: _____

M-CHAT Questionnaire:

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g. you've seen it once or twice), please answer as if the child does not do it.

- | | |
|---|--------------------|
| 1. Does your child enjoy being swung, bounced on your knee, etc? | Circle One: No Yes |
| 2. Does your child take an interest in other children? | Circle One: No Yes |
| 3. Does your child like climbing on things, such as up stairs? | Circle One: No Yes |
| 4. Does your child enjoy playing pee-a-boo/hide-and-seek? | Circle One: No Yes |
| 5. Does your child ever pretend, for example, to talk on the phone
or take care of a doll or pretend other things? | Circle One: No Yes |
| 6. Does your child ever use his/her index finger to point/to ask for something? | Circle One: No Yes |
| 7. Does your child ever use his/her index finger to point/to indicate
interest in something? | Circle One: No Yes |
| 8. Can your child play properly with small toys (e.g. cars or blocks) without
just mouthing, fiddling, or dropping them? | Circle One: No Yes |
| 9. Does your child ever bring objects over to you (parent) to show you something? | Circle One: No Yes |
| 10. Does your child look you in the eye for more than a second or two? | Circle One: No Yes |
| 11. Does your child ever seem oversensitive to noise? (e.g. plugging ears) | Circle One: No Yes |
| 12. Does your child smile in response to your face or your smile? | Circle One: No Yes |
| 13. Does your child imitate you? (e.g., you make a face-will your child imitate you?) | Circle One: No Yes |
| 14. Does your child respond to his/her name when you call? | Circle One: No Yes |
| 15. If you point at a toy across the room, does your child look at it? | Circle One: No Yes |
| 16. Does your child walk? | Circle One: No Yes |
| 17. Does your child look at things you are looking at? | Circle One: No Yes |
| 18. Does your child make unusual finger movements near his/her face? | Circle One: No Yes |
| 19. Does your child try to attract your attention to his/her own activity? | Circle One: No Yes |
| 20. Have you ever wondered if your child is deaf? | Circle One: No Yes |
| 21. Does your child understand what people say? | Circle One: No Yes |
| 22. Does your child sometimes stare at nothing or wander with no purpose? | Circle One: No Yes |
| 23. Does your child look at your face to check your reaction when
faced with something unfamiliar? | Circle One: No Yes |

Please list any concerns about your child's learning, development, and/or behavior.

This form must be completed at 18 months & 24 months of age.

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18 Month Questionnaire

17 months 0 days
through 18 months 30 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.

Baby Information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____

If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Relationship to baby:
 Parent Guardian
 Grandparent or other relative Foster parent
 Other: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "yes" even if her words are difficult to understand.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?") Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child move around by walking, rather than by crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child climb on an object such as a chair to reach something he wants (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"/>	—
5. Does your child walk down stairs if you hold onto one of her hands? She may also 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"/>	—
6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				GROSS MOTOR TOTAL —


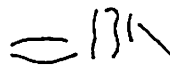



FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child stack three small blocks or toys on top of each other by himself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				FINE MOTOR TOTAL —



PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | |  |
| 3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | | Count as "yes" |
| 5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "not yet" if your child scribbles back and forth.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | | Count as "not yet" |
| | | | |  |
| | | | |  |
| 6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —* |

PROBLEM SOLVING TOTAL

*If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. While looking at herself in the mirror, does your child offer a toy to her own image? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child drink from a cup or glass, putting it down again with little spilling? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair? | <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 toddlers his age? If no, explain: YES NO

3. Can you understand most of what your child says? If no, explain: YES NO

4. Do you think your child walks, runs, and climbs like other toddlers her age? If no, explain: YES NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: YES NO

6. Do you have concerns about your child's vision? If yes, explain: YES NO

7. Has your child had any medical problems in the last several months? If yes, explain: YES NO

8. Do you have any concerns about your child's behavior? If yes, explain: YES NO

9. Does anything about your child worry you? If yes, explain: YES NO

Child's Name: _____ Date of Birth: _____



Division of Public Health,
Prevention Services Branch
Tuberculosis Program
404-657-2634 fax: 404-463-3460
<http://health.state.ga.us/programs/tb>

Tuberculosis (TB) Risk Assessment

Child Health Services

Circle Yes or No.

1. Is the child in close contact to a person sick with active TB disease? * Yes No
2. Does the child have or is at risk to have HIV? Yes No
3. Was the child or the child's parent born outside the US? Yes No
4. Is the child exposed to a person in jail or a person who has been in jail in the past five years? Yes No
5. Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home? Yes No
6. Is the child exposed to drug users or migrant farm workers? Yes No
7. Does the child have a health problem that lowers the immune system? Yes No
8. Does the child live in a community that has a high risk for TB? Yes No
9. Has the child traveled to or had a visitor from any foreign country since the last visit? Yes No
10. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or an abnormal chest x-ray? * Yes No

** Call the Health Department*

Any 'yes' answer means the child is High Risk and should have a Mantoux TB skin test. The test should be read by a Health Professional.

For your child's health, this form is required to be completed at the following visits:

DPH06/057W

1 month

6 month

12 month

18 month

Rev. 08.2006

2 year through 18 year

**PARENTS
PLEASE
STOP HERE**

**OFFICE USE ONLY
BEYOND
THIS
PAGE**



18 Month ASQ-3 Information Summary

17 months 0 days through
18 months 30 days

Child's name: _____ Date ASQ completed: _____
 Child's ID #: _____ Date of birth: _____
 Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

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	13.06		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	37.38		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	34.32		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	25.74		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	27.19		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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. Concerns about vision?
Comments: | YES | No |
| 2. Talks like other toddlers his age?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Walks, runs, and climbs like other toddlers?
Comments: | Yes | NO | 9. Other concerns?
Comments: | YES | No |
| 5. Family history of hearing impairment?
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						