

Patient Name: _____

Lead Risk Assessment Questionnaire

Circle Yes or No

*If Yes, please explain

- | | | | |
|--|-----|----|-------|
| 1. Does your child live in or often visit a house that may have been built before 1978? | Yes | No | _____ |
| 2. Does your child live in or often visit a house that is being remodeled or is having paint removed? | Yes | No | _____ |
| 3. Does your child live with or often visit another child that has an elevated blood lead level? | Yes | No | _____ |
| 4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it? | Yes | No | _____ |
| 5. Does your child chew on or eat any non-food items like paint chips or dirt? | Yes | No | _____ |
| 6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead? | Yes | No | _____ |
| 7. Does your child receive medicines such as <i>greta</i> , <i>azarcon</i> , <i>kohl</i> or <i>pay-loo-ah</i> ? | Yes | No | _____ |

Risk Factors for Hearing Loss

- | | | |
|---|-----|----|
| 1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay | Yes | No |
| 2. Family history of permanent childhood hearing loss | Yes | No |
| 3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion | Yes | No |
| 4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis | Yes | No |
| 5. Craniofacial anomalies, especially involving the ear and temporal bone | Yes | No |
| 6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction | Yes | No |
| 7. Syndromes associated with hearing loss or progressive or late-onset hearing loss | Yes | No |
| 8. Neurodegenerative disorders or sensory motor neuropathies | Yes | No |
| 9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis | Yes | No |
| 10. Head trauma | Yes | No |
| 11. Chemotherapy | Yes | No |
| 12. Recurrent or persistent ear infection for at least 3 months | Yes | No |

Parent Signature _____

Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

- | | | |
|---|---------------|------------|
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |

Patient Name: _____

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

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◆ **30 Month** ◆
Questionnaire

Please provide the following information.

Child's name: _____

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: _____



name _____

YES SOMETIMES NOT YET




COMMUNICATION *Be sure to try each activity with your child.*

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|-------|
| 1. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly <i>name</i> at least one picture? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Without giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?
a. "Put the toy on the table." d. "Find your coat."
b. "Close the door." e. "Take my hand."
c. "Bring me a towel." f. "Get your book." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least <i>seven</i> body parts? (She can point to parts of herself, you, or a doll.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Does your child make sentences that are three or four words long?
Please give an example:

_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Without giving him help by pointing or using gestures, ask your child to "Put the shoe <i>on</i> the table" and "Put the book <i>under</i> the chair." Does your child carry out both of these directions correctly? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. 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," and "Crying") You may ask, "What is the dog (or boy) doing?" | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

COMMUNICATION TOTAL _____

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

- | | | | | | |
|--|---|--------------------------|--------------------------|--------------------------|-------|
| 1. Does your child run fairly well, stopping herself without bumping into things or falling? |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Does your child walk either up or down at least two steps by himself? You can look for this at a store, on a playground, or at home. (Check "yes" even if he holds onto the wall or railing.) |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Name _____

YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

4. Does your child jump with both feet leaving the floor at the same time?



5. 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.) He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)



 _____*

6. Does your child stand on one foot for about 1 second without holding onto anything?



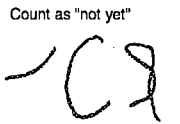
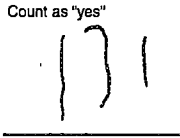
GROSS MOTOR TOTAL _____

**If gross motor item 5 is marked "yes" or "sometimes," mark gross motor item 2 as "yes."*

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

1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

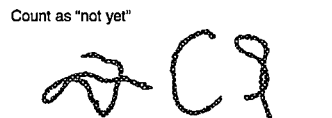
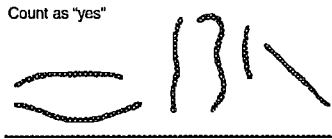
2. After he watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask your child to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?



3. Does your child thread a shoelace through either a bead or eyelet of a shoe?



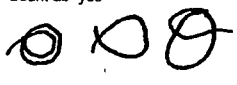
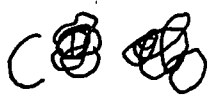
4. After she watches you draw a line from one side of the paper to the other side, ask your child to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?






name _____

YES SOMETIMES NOT YET

FINE MOTOR *(continued)*

5. After he watches you draw a single circle, ask your child to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?
 Count as "yes" 
 Count as "not yet"  _____
6. Does your child turn pages in a book, one page at a time? _____
- FINE MOTOR TOTAL _____

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

1. When looking in the mirror, ask, "Where is _____?" (Use your child's name.) Does your child point to her image in the mirror?  _____
2. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it? _____
3. 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.)  _____
4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person? Responses like "snowman," "boy," "man," "girl," and "Daddy" are correct. Please write your child's response here:
 _____  _____
5. When you say, "Say seven three," does your child repeat *just* the two numbers in the correct 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. _____
6. After she draws a "picture," even a simple scribble, does your child tell you what she drew? You may say, "Tell me about your picture," or ask, "What is this?" to prompt her. _____
- PROBLEM SOLVING TOTAL _____

Name _____

PERSONAL-SOCIAL

Be sure to try each activity with your child.

1. If you do any of the following gestures, does your child copy at least one of them? _____
a. Open and close your mouth. c. Pull on your earlobe.
b. Blink your eyes. d. Pat your cheek.
2. Does your child use a spoon to feed himself with little spilling? _____
3. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if she cannot turn? _____
4. Does your child put on a coat, jacket, or shirt by himself? _____
5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist? _____
6. When he is looking in a mirror and you ask, "Who is in the mirror?" does your child say either "Me" or his own name? _____

PERSONAL-SOCIAL TOTAL _____

OVERALL

Parents and providers may use the space below or the back of this sheet for additional comments.

1. Do you think your child hears well? YES NO
If no, explain: _____
2. Do you think your child talks like other toddlers her age? YES NO
If no, explain: _____
3. Can you understand most of what your child says? YES NO
If no, explain: _____
4. Do you think your child walks, runs, and climbs like other toddlers his age? YES NO
If no, explain: _____
5. Does either parent have a family history of childhood deafness or hearing impairment? YES NO
If yes, explain: _____
6. Do you have any concerns about your child's vision? YES NO
If yes, explain: _____
7. Has your child had any medical problems in the last several months? YES NO
If yes, explain: _____
8. Does anything about your child worry you? YES NO
If yes, explain: _____



Developmental Drawing Sheet

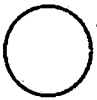
Please use this sheet to allow your child to show us their creativity. This is not only fun for your child, but also allows us to observe fine motor and cognitive skills. Several age groups are listed. Find your child's age and ask them to complete the activities for that age. Remember to allow your child to practice these skills with you at home. Coloring is fun and great for your child's brain development. When you are done, draw a picture on the back of the page.

15 Months- 30 Months Old:

Let your child use your pen and clipboard to have fun and scribble in the space below.

3 & 4 Years Old:

Ask your child to copy the circle and cross pictured below & draw a person.



5 Years Old:

Ask your child to draw a circle and cross, copy the square and triangle pictured below, print some letters and numbers, & draw a person.

CIRCLE:

CROSS:



Draw us a picture below