



# Mandatory Blood Lead Screening Questionnaire

## To be completed at each KBH Screen from 6 to 72 months

Does your child: (circle response received)	DATE: (MM/DD/YYYY)					
1) Live in or visit a house or apartment built before 1960? (This could include a day care center, preschool, the home of a baby-sitter or relative, etc.)	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No
2) Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No
3) Have a family member with an elevated blood lead level?	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No
4) Interact with an adult whose job or hobby involves exposure to lead? (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery).	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No
5) Live near a lead smelter, battery plant or other lead industry? (Ammunition/explosives, auto repair/auto body, cable/wiring stripping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work).	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No
6) Use pottery, ceramic, or crystal wear for cooking, eating, or drinking? One positive response to the above questions requires a blood lead level test. Please, remember blood lead level tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No
Interviewing Staff Initials						

Staff Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I.D. Number: \_\_\_\_\_



# Ages & Stages Questionnaires®

28 months 16 days through 31 months 15 days

## 30 Month Questionnaire



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: \_\_\_\_\_



# 30 Month Questionnaire

28 months 16 days  
through 31 months 15 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:

- 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 \_\_\_\_\_.

### Notes:

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## COMMUNICATION

- |   | YES                   | SOMETIMES             | NOT YET               | _____ |
|---|-----------------------|-----------------------|-----------------------|-------|
| 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="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Without your giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| <input type="radio"/> a. "Put the toy on the table." <input type="radio"/> d. "Find your coat."<br><input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand."<br><input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book."                  |                       |                       |                       |       |
| 3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least <i>seven</i> body parts? (She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least <i>three</i> different body parts.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Does your child make sentences that are three or four words long? Please give 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>  |                       |                       |                       |       |
| 5. Without giving your child help by pointing or using gestures, ask him to "put the book <i>on</i> the table" and "put the shoe <i>under</i> the chair." Does your child carry out both of these directions correctly?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 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," or "crying")? You may ask, "What is the dog (or boy) doing?"  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

COMMUNICATION TOTAL \_\_\_\_\_

**GROSS MOTOR**

		YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child walk either up or down at least two steps by himself? He may 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"/>	—
3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child jump with both feet leaving the floor at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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.) She may hold onto the railing or wall.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—*
6. Does your child stand on one foot for about 1 second without holding onto anything?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<b>GROSS MOTOR TOTAL</b>					—

\*If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."

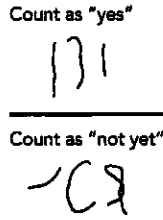
**FINE MOTOR**

YES                      SOMETIMES                      NOT YET

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 your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him 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?



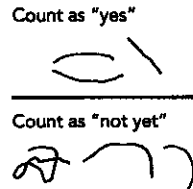
                                                                 \_\_\_\_\_

3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?



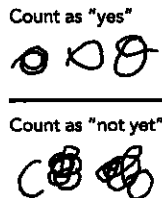
                                                                 \_\_\_\_\_

4. After your child watches you draw a line from one side of the paper to the other side, ask her 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?



                                                                 \_\_\_\_\_

5. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?



                                                                 \_\_\_\_\_

6. Does your child turn pages in a book, one page at a time?

                                                                 \_\_\_\_\_

FINE MOTOR TOTAL \_\_\_\_\_

**PROBLEM SOLVING**

YES                      SOMETIMES                      NOT YET

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 (for example, to get a toy on a counter or to "help" you in the kitchen)?

                                                                 \_\_\_\_\_

**PROBLEM SOLVING** (continued)

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.)



YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same 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.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? (You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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PROBLEM SOLVING TOTAL \_\_\_\_\_

**PERSONAL-SOCIAL**

1. If you do any of the following gestures, does your child copy at least one of them?

- a. Open and close your mouth.
- b. Blink your eyes.
- c. Pull on your earlobe.
- d. Pat your cheek.

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

2. Does your child use a spoon to feed himself with little spilling?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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3. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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4. Does your child put on a coat, jacket, or shirt by himself?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------

5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------

6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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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 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

5. Do you think your child walks, runs, and climbs like other toddlers 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

**OVERALL** (continued)

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





# 30 Month ASQ-3 Information Summary

28 months 16 days through  
31 months 15 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	33.30		●	●	●	●	●	●	●	●	●	○	○	○	○
Gross Motor	36.14		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	19.25		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	27.08		●	●	●	●	●	●	●	●	○	○	○	○	○
Personal-Social	32.01		●	●	●	●	●	●	●	●	●	○	○	○	○

**2. TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |   |               |   |               |
|---|---------------|---|---------------|
| 1. Hears well?<br>Comments:                                     | Yes <b>NO</b> | 6. Family history of hearing impairment?<br>Comments: | <b>YES</b> No |
| 2. Talks like other toddlers his age?<br>Comments:              | Yes <b>NO</b> | 7. Concerns about vision?<br>Comments:                | <b>YES</b> No |
| 3. Understand most of what your child says?<br>Comments:        | Yes <b>NO</b> | 8. Any medical problems?<br>Comments:                 | <b>YES</b> No |
| 4. Others understand most of what your child says?<br>Comments: | Yes <b>NO</b> | 9. Concerns about behavior?<br>Comments:              | <b>YES</b> No |
| 5. Walks, runs, and climbs like other toddlers?<br>Comments:    | Yes <b>NO</b> | 10. Other concerns?<br>Comments:                      | <b>YES</b> 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						