



# 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	Yes	Yes	Yes
	No	No	No	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	Yes	Yes	Yes
	No	No	No	No	No	No	No	No	No
3) Have a family member with an elevated blood lead level?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	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	Yes	Yes	Yes
	No	No	No	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	Yes	Yes	Yes
	No	No	No	No	No	No	No	No	No
6) Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	No	No	No	No	No	No	No	No	No
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?									
Interviewing Staff Initials									

Staff Signature:


Patient Name:

I.D. Number:



# 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 \_\_\_\_\_.

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## 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)

YES                      SOMETIMES                      NOT YET                      \_\_\_\_\_

                                                                 \_\_\_\_\_

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**

YES                      SOMETIMES                      NOT YET                      \_\_\_\_\_

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.)




                                                                 \_\_\_\_\_

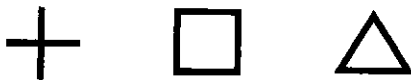
**GROSS MOTOR** (continued)

- |   | YES                   | SOMETIMES             | NOT YET               |   |
|---|-----------------------|-----------------------|-----------------------|---|
| 4. Does your child walk on his tiptoes for 15 feet (about the length of a large car)? (You may show him how to do this.)  | <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? (You may give her two tries on each foot. Mark "sometimes" if she can hop on one foot only.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child skip using alternating feet? (You may show him how to do this.)  | <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? (Mark "sometimes" if your child goes off the line three times.)  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| _____  |                       |                       |                       |   |
| 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, and 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? (Carefully watch your child's use of scissors for safety reasons.)   | <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? (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.)   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



(Space for child's shapes)

**FINE MOTOR** (continued)

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.)

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

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.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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(Space for adult's printing)

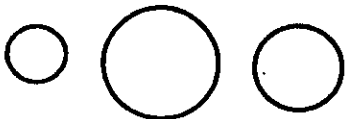
(Space for child's printing)

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

**PROBLEM SOLVING**

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.)

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



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.)

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

**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"/> | <input type="radio"/> | <input type="radio"/> |     |
| <input type="radio"/> b. Age   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |
| <input type="radio"/> c. City he lives in  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |
| <input type="radio"/> d. Last name   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |
| <input type="radio"/> e. Boy or girl   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |
| <input type="radio"/> f. Telephone number  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |

**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? (She goes to the bathroom, sits on the toilet, wipes, and flushes.) 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

[Large rounded rectangular box for explanation]

2. Do you think your child talks like other children her age? If no, explain:

YES  NO

[Large rounded rectangular box for explanation]

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

YES  NO

[Large rounded rectangular box for explanation]

4. Can other people understand most of what your child says? If no, explain:

YES  NO

[Large rounded rectangular box for explanation]



**OVERALL** (continued)

5. Do you think your child walks, runs, and climbs like other children his age?  
If no, explain:  YES  NO

[Empty rounded rectangular box for explanation]

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

[Empty rounded rectangular box for explanation]

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

[Empty rounded rectangular box for explanation]

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

[Empty rounded rectangular box for explanation]

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

[Empty rounded rectangular box for explanation]

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

[Empty rounded rectangular box for explanation]



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