CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
3 YEAR VISIT

Bright Futures™

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your child's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your child's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your child is able to do.

- ☐ Go to the bathroom and urinate by herself.
- ☐ Put on a coat, jacket, or shirt by himself.
- ☐ Eat by herself.
- ☐ Begin to play make-believe.
- ☐ Play and share with others.
- ☐ Use 3-word sentences.
- ☐ Speak so strangers can understand 75% of what he says.
- ☐ Tell you a story from a book or TV.
- ☐ Compare things using words such as *bigger* and *shorter*.
- ☐ Understand simple prepositions, such as *on* or *under.*
- ☐ Pedal a tricycle.
- ☐ Climb on and off a couch or chair.
- ☐ Jump forward.
- ☐ Draw a single circle.
- ☐ Draw a person with head and one other body part.
- ☐ Cut with child scissors.

PATIENT NAME: _____ DATE: _____

Please print.

3 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child have a dentist?	O Yes	O No	O Unsure
	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your child infected with HIV?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Do you have enough heat, hot water, electricity, and working appliances?	O Yes	O No
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	O No	O Yes
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Positive Family Interactions		
Are your family members loving and affectionate with one another?	O Yes	O No
Do you praise your child when he is being good?	O Yes	O No
Do you have ways to constructively handle anger and settle disputes in your family?	O Yes	O No
Does everyone who cares for your child set the same limits for your child?	O Yes	O No
Do you allow your child to make choices, such as what clothes to wear or what books to read?	O Yes	O No
Do you use simple words when asking your child a question or telling her what to do?	O Yes	O No
Taking Care of Yourself		
Do you take time for yourself?	O Yes	O No
Do you feel you are able to balance family and work?	O Yes	O No
Do you spend time alone with your partner?	O Yes	O No

PLAYING WITH SIBLINGS AND PEERS

Does your child engage in fantasy play with dolls, toy animals, or blocks?	O Yes	O No
Do you spend time alone with your child doing things you both enjoy?	O Yes	O No
Does your child have chances to play with other children (such as on playdates and at preschool)?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

3 YEAR VISIT

PLAYING WITH SIBLINGS AND PEERS (*CONTINUED*)

When your child plays with other children, do you help him learn how to take turns?		O Yes	O No
If you have other children, do they get along with each other?	O NA	O Yes	O No
Are you expecting or thinking about having another child?		O No	O Yes

READING AND TALKING WITH YOUR CHILD

Do you read, sing songs, or play word games with your child every day?	O Yes	O No
When you are reading together, do you ask your child questions about the pictures or story in the book?	O Yes	O No
Do you encourage your child to tell you about his day?	O Yes	O No
Does your family speak more than one language at home?	O No	O Yes

EATING HEALTHY AND BEING ACTIVE

Nutritious Foods		
Does your child drink water every day?	O Yes	O No
How many ounces of milk does your child drink on most days?	_____ oz	
Do you offer your child a variety of foods, including vegetables, fruits, and foods rich in protein, such as meat, eggs, chicken, or fish?	O Yes	O No
Is your child willing to try new flavors and food textures?	O Yes	O No
Do you let your child decide how much to eat and when to stop?	O Yes	O No
Promoting Physical Activity and Limiting TV		
Are you physically active together as a family, such as going on walks or playing in the park?	O Yes	O No
Does your child play actively for at least 1 hour a day?	O Yes	O No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	O No	O Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No

SAFETY

Car and Home Safety		
Is your child buckled securely in a car safety seat in the back seat every time he rides in a vehicle?	O Yes	O No
Are you having any problems with your car seat?	O No	O Yes
Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O No
Do you cut foods such as grapes and hot dogs into small pieces to prevent choking?	O Yes	O No
Does your child play in a driveway or close to the street?	O No	O Yes
Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.)	O Yes	O No
Water Safety		
Are there swimming pools near your home?	O No	O Yes
Do you always stay within arm's reach of your child when he is in or near water?	O Yes	O No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	O Yes	O No
Pets		
Do you own a pet?	O No	O Yes
Have you taught your child how to behave around animals so she does not get bitten or scratched?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

3 YEAR VISIT

SAFETY (*CONTINUED*)

Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	○ No	○ Yes
If yes, is the gun unloaded and locked up?	○ Yes	○ No
If yes, is the ammunition stored and locked up separately from the gun?	○ Yes	○ No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

ASQ-3™

36 Month Questionnaire

34 months 16 days through 38 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.

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:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least *seven* body parts? *(She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)*	○	○	○	____
2. Does your child make sentences that are three or four words long? Please give an example:	○	○	○	____
3. Without giving your child help by pointing or using gestures, ask him to "put the book *on* the table" and "put the shoe *under* the chair." Does your child carry out both of these directions correctly?	○	○	○	____
4. 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?"	○	○	○	____
5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle and ask your child to move the zipper *down*. Return the zipper to the middle and ask your child to move the zipper *up*. Do this several times, placing the zipper in the middle before asking your child to move it up or down. Does your child consistently move the zipper up when you say "up" and down when you say "down"?	○	○	○	____
6. When you ask, "What is your name?" does your child say both her first and last names?	○	○	○	____

COMMUNICATION TOTAL ____

E101360200

GROSS MOTOR

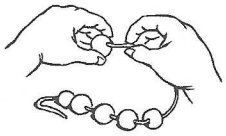
		YES	SOMETIMES	NOT YET	
1. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		○	○	○	___
2. Does your child jump with both feet leaving the floor at the same time?		○	○	○	___
3. Does your child walk up stairs, using only one foot on each stair? *(The left foot is on one step, and the right foot is on the next.)* She may hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*		○	○	○	___
4. Does your child stand on one foot for about 1 second without holding onto anything?		○	○	○	___
5. While standing, does your child throw a ball *overhand* by raising his arm to shoulder height and throwing the ball forward? *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")*		○	○	○	___
6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?		○	○	○	___

GROSS MOTOR TOTAL ___

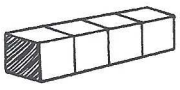
FINE MOTOR

		YES	SOMETIMES	NOT YET	
1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, 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 vertical direction?	Count as "yes" 1 3 1 / Count as "not yet" 1 C 8	○	○	○	___

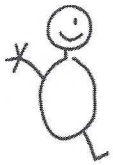
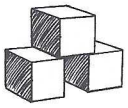
FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	____
3. 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? Count as "yes"  Count as "not yet" 	○	○	○	____
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? Count as "yes"  Count as "not yet" 	○	○	○	____
5. Does your child try to cut paper with child-safe scissors? He does not need to cut the paper but must get the blades to open and close while holding the paper with the other hand. *(You may show your child how to use scissors. Carefully watch your child's use of scissors for safety reasons.)* 	○	○	○	____
6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?	○	○	○	____
			FINE MOTOR TOTAL	____

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. 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.)* 	○	○	○	____
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)*

	YES	SOMETIMES	NOT YET	
3. 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: 	○	○	○	____
4. 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.)*	○	○	○	____
5. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it? 	○	○	○	____
6. When you say, "Say 'five eight three,'" does your child repeat *just* the three numbers in the same order? *Do not repeat the numbers.* If necessary, try another series of numbers and say, "Say 'six nine two.'" *(Your child must repeat just one series of three numbers for you to answer "yes" to this question.)*	○	○	○	____
		PROBLEM SOLVING TOTAL		____

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child use a spoon to feed herself with little spilling?	○	○	○	____
2. Does your child push a little wagon, stroller, or toy on wheels, steering it around objects and backing out of corners if he cannot turn?	○	○	○	____
3. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?	○	○	○	____
4. Does your child put on a coat, jacket, or shirt by himself?	○	○	○	____
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?	○	○	○	____
6. Does your child take turns by waiting while another child or adult takes a turn?	○	○	○	____
		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 children 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 children 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

Albemarle Pediatrics Annual Questionnaire

Patient Name: _____ Date of Birth: _____

Form Completed by: _____ Date Completed: _____

(Please circle answer)

Has your child been diagnosed with any serious illnesses or medical conditions within the last year (i.e. seizures, diabetes)?
Yes No Explain _____

Has your child had any serious injuries or accidents within the last year (i.e. fractures, concussions)?
Yes No Explain _____

Has your child had any surgery within last year?
Yes No Explain _____

Has your child been hospitalized within the last year?
Yes No Explain _____

Have there been any changes in the family medical history within the last year (i.e. high blood pressure, diabetes)?
Yes No Explain _____

Does your child take any over the counter medications or herbal supplements/vitamins?
Yes No Explain _____

Do you have transportation problems to any medical appointments?
Yes No Explain _____

Please list the following:

Dentist _____ Phone Number _____

Counselor_____ Phone Number _____

Specialist _____ Phone Number _____
_____ Phone Number _____
_____ Phone Number _____

Please list any additional concerns you may have regarding your child:
_____
_____