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:

- ☑ 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. Without your giving help by pointing or repeating directions, does your child follow three directions that are *unrelated* 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."	○	○	○	___
2. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:	○	○	○	___
3. When talking about something that already happened, does your child use words that end in "-ed," such as "walk*ed*," "jump*ed*," or "play*ed*"? Ask your child questions, such as "How did you get to the store?" ("We walk*ed*.") "What did you do at your friend's house?" ("We play*ed*.") Please write an example:	○	○	○	___
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:	○	○	○	___

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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.)*	○	○	○	___

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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.)*

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.)*

6. Does your child skip using alternating feet? *(You may show him how to do this.)*

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.)*

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.

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.)*

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.)*

(Space for child's shapes)

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FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
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.)*	○	○	○	___

V H T C A

(Space for child's letters)

	YES	SOMETIMES	NOT YET	
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.)*	○	○	○	___

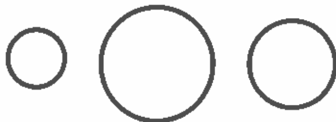
(Space for adult's printing)

(Space for child's printing)

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
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	
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.)*	○	○	○	___

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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."	○	○	○	___
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 *hard*, and a pillow is *soft*."	○	○	○	___

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.)

	YES	SOMETIMES	NOT YET	
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.)*	○	○	○	___

3 1 2

	YES	SOMETIMES	NOT YET	
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.)*	○	○	○	___

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?	○	○	○	___
2. Does your child wash her hands and face using soap and water and dry off with a towel without help?	○	○	○	___
3. Does your child tell you at least four of the following? Please mark the items your child knows.	○	○	○	___

- ○ a. First name
- ○ b. Age
- ○ c. City he lives in
- ○ d. Last name
- ○ e. Boy or girl
- ○ f. Telephone number

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PERSONAL-SOCIAL *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your child dress and undress himself, including buttoning medium-size buttons and zipping front zippers?	◯	◯	◯	___
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.	◯	◯	◯	___
6. Does your child usually take turns and share with other children?	◯	◯	◯	___

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

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OVERALL (continued)

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

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

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Parent or Guardian to Fill Out

Patient Name: ______________________ Date: ____________

Patient Date of Birth: __________________

Pediatric Symptom Checklist-17 (PSC-17)

As per the **American Academy of Pediatrics** clinical guidelines, depression screenings for anyone 5 years and older are now standard of care in pediatric offices. Please answer the questions on the screening questionnaire. Your clinician will review the form during your appointment today.

	Please mark under the heading that best fits your child.			*For Office Use*		
Does your child:	Never	Sometimes	Often	I	A	E
1. Feel sad.	○	○	○			
2. Feel hopeless.	○	○	○			
3. Feel down on him/herself.	○	○	○			
4. Worry a lot.	○	○	○			
5. Seem to be having less fun.	○	○	○			
6. Fidget, is unable to sit still.	○	○	○			
7. Daydream too much.	○	○	○			
8. Distract easily.	○	○	○			
9. Have trouble concentrating.	○	○	○			
10. Act as if driven by a motor.	○	○	○			
11. Fight with other children.	○	○	○			
12. Not listen to rules.	○	○	○			
13. Not understand other people's feelings.	○	○	○			
14. Tease others.	○	○	○			
15. Blame others for his/her troubles.	○	○	○			
16. Refuse to share.	○	○	○			
17. Take things that do not belong to him/her.	○	○	○			
TOTAL						

*Patient Name:*______________________________ *DOB:*__________

Risk Assessment ***12 months to 6 years***

TB risk

Question		
Was your child born in Africa/Asia/Latin America/ Caribbean/Eastern Europe?	YES	NO
Has your child traveled to Africa/Asia/Latin America/ Caribbean/Eastern Europe?	YES	NO
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	YES	NO
Is your child infected with HIV?	YES	NO
Has your child spent time with anyone during the past year who has been in jail or a shelter, uses illegal drugs, or has HIV?	YES	NO

Lead

Question		
Does your child live in or frequently visit a house/ building built before 1950?	YES	NO
Does your child live in or frequently visit a house/ building built before 1978 with recent or ongoing renovations within the last 6 months?	YES	NO
Does your child have any siblings/housemates/ playmates that are being treated for lead poisoning?	YES	NO

Fluoride

Question		
Do you have well water?	YES	NO
Does your family use bottled water exclusively?	YES	NO

Anemia

Question		
Does your child consume more than 24 ounces of milk per day?	YES	NO
Is your child on a vegetarian or vegan diet?	YES	NO
Has your child ever been treated for anemia?	YES	NO
If your child is 18 months of age or older, is his or her diet lacking in iron-rich foods such as meat, eggs, beans, leafy green vegetables, or iron-fortified cereals?	YES	NO

Cholesterol

Question		
Does your child have a parent or grandparent who had a stroke or heart problem before age 55?	YES	NO
Does your child have a parent with elevated blood cholesterol (240 or higher) or who is taking cholesterol medication?	YES	NO

January 2016rev

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name:

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification
I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: ______________________ Date (m/d/yyyy):

Date of Exam (if Different):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here:

Public Health
HEALTH AND HUMAN SERVICES