www.m-chat.org

Child's name ______________ Date ______________

Age ______________ Relationship to child ______________

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

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Benton Pediatrics, Inc.
Board Certified Pediatrics
5612 N.W. 43rd Street • Gainesville, FL 32653-3332 • (352) 376-4542

Cholesterol Screening Questionnaire

Today's Date: ______________________________

Patient Name: ________________________ Date of Birth:___________

Please answer this questionnaire from the patient's point of view.
If you are answering for the patient, answer as if you are the patient.

Yes ___ No ___ Don't know ___ — 1. Does either one of your parents have a cholesterol level greater the 240?

Yes ___ No ___ Don't know ___ — 2. Does any aunt, uncle, grandparent or parent have a history of heart disease? If yes, at what age was the heart disease first diagnosed? _________

Yes ___ No ___ Don't know ___ — 3. Is there a family history of problems with lipids (dyslipidemia)?

Yes ___ No ___ Don't know ___ — 4. Do you have diabetes, hypothyroidism or any other endocrine problems?

Yes ___ No ___ Don't know ___ — 5. Do you have kidney or liver disease?

Yes ___ No ___ Don't know ___ — 6. Do you smoke?

Yes ___ No ___ Don't know ___ — 7. Are you overweight?

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FROM 1 TO 4 YEARS (Part 1)

Framingham Safety Survey

Name ______________________________ Date ______________

Please X through one answer for each question.

	Question				
1.	Do you leave your child alone at home?	Frequently	Occasionally	Never	
2.	Are any of your baby-sitters younger than 13 years?	Yes	Don't know	No	
3.	Do you keep plastic wrappers, plastic bags, and balloons away from your children?	Always	Sometimes	Never	
4.	Do you know how to prevent your child from choking?	Yes	No		
5.	Do you have mechanical garage doors?	Yes	No		
6.	Are your operable window guards in place?	All windows	Some windows	None	
7.	Is your child in the yard while the lawn mower is in use?	Never	Sometimes	Have no mower	
8.	Do you place gates at the entrance to stairways (for children younger than 3 years)?	Always	Sometimes	Never	All children 3 or older
9.	Is your baby's crib near a window or drapery covering?	Yes	No		
10.	Do you check for safety hazards in homes of friends or relatives where your child may play?	Always	Sometimes	Never	
11.	Have any of your children ever had an injury requiring a visit to the doctor or hospital?	Yes. How many visits? ________	Don't remember	No	
12.	Is there a gun in your home or the home where your child plays or is cared for?	Yes	Don't know	No	
13.	Do you keep household products, medicines (including acetaminophen and iron), and sharp objects out of the reach of your child and in locked cabinets?	Always	Sometimes	Never	
14.	Do you dispose of old medicines?	Always	Sometimes	Never	
15.	Do you have safety caps on all bottles of medicine?	Always	Sometimes	Never	
16.	Does your child chew on paint chips or window sills?	Frequently	Occasionally	Never	
17.	Do you have the number of the Poison Help Line by your phone?	Yes	No		
18.	How frequently is the heating system checked where you live?	Never	At least once a year	Don't know	

American Academy of Pediatrics

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The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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