Dear Parents of Guardians of our Pediatric Patients,

Your child is due for an appointment for either an 18-month or 24-month Well-Child visit. At this visit, we will be screening for Autism spectrum disorders (ASDs).

Autism spectrum disorders (ASDs) are a group of related brain-based disorders that affect a child's behavior, social, and communication skills. They include three pervasive developmental disorders (PDD):

- Autistic Disorder
- Asperger syndrome
- PDD-not otherwise specified

Approximately 1 in 150 children are diagnosed with an ASD. ASDs are lifelong conditions with no known cure. However, children with ASD can progress developmentally and learn new skills. Some children may improve so much that they no longer meet the criteria for ASD, although milder symptoms may often persist. We strongly believe in the importance of early and continuous surveillance and screening for ASD to ensure that children are identified and receive access to services as early as possible. The sooner autism is identified, the sooner an intervention program can start.

About 25% of children will seem to have normal development until about 18 months, after which they will gradually or suddenly stop talking, stop waving goodbye, stop turning their head when their name is called, and withdraw into a shell and seem more distant and less interested in their surroundings.

Attached is a questionnaire called M-CHAT (Modified Checklist for Autism in Toddlers). This is to be completed at age 18 months **and** at 24 months. We would like you to answer the questions to the best of your ability. Please bring the completed form with you to your child's office appointment. We will score this questionnaire and let you know the results.

Thank you for your participation.

David McAnulty, M.D.
Medical Director
Northwest Primary Care Group

M-CHAT

Date: ______________________

Patient's Name: ______________________ Filled out by: ______________________

Date of Birth: ______________________ Relationship to patient: ______________________

Practitioner: ______________________

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc.?	YES	NO
2. Does your child take an interest in other children?	YES	NO
3. Does your child like climbing on things, such as up stairs?	YES	NO
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	YES	NO
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	YES	NO
6. Does your child ever use his index finger to point, to ask for something?	YES	NO
7. Does your child ever use his/her index finger to point, to indicate interest in something?	YES	NO
8. Can your child play properly with toys (e.g.,cars or bricks) without just mouthing, fiddling, or dropping them?	YES	NO
9. Does your child ever bring objects over to you (parent) to show you something?	YES	NO
10. Does your child look you in the eye for more than a second or two?	YES	NO
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)	YES	NO
12. Does your child smile in response to your face or your smile?	YES	NO
13. Does your child imitate you? (e.g., you make a face-will your child imitate it?)	YES	NO
14. Does your child respond to his/her name when you call?	YES	NO
15. If you point at a toy across the room, does your child look at it?	YES	NO
16. Does your child walk?	YES	NO
17. Does your child look at things you are looking at?	YES	NO
18. Does your child make unusual finger movements near his/her face?	YES	NO
19. Does your child try to attract your attention to his/her own activity?	YES	NO
20. Have you ever wondered if you child is deaf?	YES	NO
21. Does your child understand what people say?	YES	NO
22. Does you child sometimes stare at nothing or wander with no purpose?	YES	NO
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	YES	NO

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2 YEAR
PEDIATRIC DEVELOPMENTAL SCREENING

Date: ______________________

Name: ____ DOB:___________ Male Female

Physician Signature: ____

Instructions: Please answer the questions below about your child by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have any concerns about your child's health?	NO	YES
Any problems with previous immunizations?	NO	YES
Feeding/ Nutrition		
Is your child drinking milk?	YES	NO
How many ounces per day?		
What type of milk?		
Does your child have fruits or vegetables at every meal?	YES	NO
Are you giving your child mostly whole grains?	YES	NO
Do you avoid giving your child choking foods (raw vegetables, nuts, hotdogs, popcorn)?	YES	NO
Does your family eat junk foods (chips, cookies, crackers,candy) or fast foods daily?	NO	YES
Does your child drinking from a bottle?	NO	YES
Does your child drink juice or other sweetened drinks?	NO	YES
Is your child taking any vitamins or supplements?	YES	NO
Lipids		
Have any parents or grandparents experienced a stroke or heart attack before age 55?	NO	YES
Do either parent have high cholesterol or are on cholesterol medication?	NO	YES
Oral Health		
Are cavities a problem for you or anyone in your family?	NO	YES
Are you using a soft toothbrush or cloth to clean child's teeth two times a day?	YES	NO
Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Do you have a dentist for your child?	YES	NO
Elimination		
Does your child have problems with bowel movements (pooping)?	ÞU	ŸÒÙ
Do you have any questions about toilet training?	ÞU	ŸÒÙ
Does your child tell you when the diaper needs to be changed?	YES	NO
Activity/Exercise/Screen time		
Does your child watch TV?	NO	YES
Is there a TV in your child's bedroom?	NO	YES
Do you read to your child every day?	YES	NO
Sleep		
Does your child sleep through the night?	YES	NO
Do you have a bedtime routine?	YES	NO
Does your child fall asleep on their own in their own bed?	YES	NO
Does your child snore more than a little?	NO	YES
Social Stressors		
Are you able to take some time for yourself?	YES	NO
Have you had any major changes or stresses in your family recently?	NO	YES

2 YEAR PEDIATRIC DEVELOPMENTAL SCREENING

Name: ____ DOB: ___________

Do you ever worry your family will go hungry?	NO	YES
Do you have daycare concerns?	NO	YES
Does your partner ever hurt you or your children?	NO	YES
Behavior		
Does your child display excessive tantrums?	NO	YES
Do you have questions about discipline?	NO	YES
Do you praise your child when they are behaving well?	YES	NO
Do you give your child choices?	YES	NO
Development		
Does your child have a fifty word vocabulary?	YES	NO
Do they speak in two to three word phrases (“More milk” or Hi Mom”)?	YES	NO
Does you child know six or more body parts?	YES	NO
Can they walk up and down stairs while holding on?	YES	NO
Does your child copy things that you do?	YES	NO
Can your child carry out a two-step command?	YES	NO
Can they turn one page at a time?	YES	NO
Can they name some pictures in books?	YES	NO
Can they jump with both feet off the floor?	YES	NO
Do they throw a ball overhand?	YES	NO
Can they hold a cup with one hand?	YES	NO
Can they kick a ball?	YES	NO
Are they trying to write with a pencil?	YES	NO
Lead		
Are you living in a house built prior to 1978?	NO	YES
Is there any peeling or chipping paint?	NO	YES
Is there any recent, ongoing, or planning of remodeling?	NO	YES
Has a sibling or play mate ever had lead poisoning?	NO	YES
Safety		
Is your child’s crib mattress at the lowest position?	YES	NO
Do you watch your child when they are playing outside?	YES	NO
Do you keep your child away from vehicles, lawn mowers, driveways, and streets?	YES	NO
Does you child wear a helmet when on a tricycle or bicycle?	YES	NO
Is your child exposed to anyone who smokes?	NO	YES
Is there a gun in the home?	NO	YES
QÁ^•ÉÃs it locked or in a safe place?	ŸÒÙ	ÞU
Does your child ride in a forward-facing safety seat in the back seat?	YES	NO
Do you use sunscreen on your child for prolonged sun exposure?	YES	NO
Do you have the number for Poison Control?	YES	NO
Tuberculosis		
Has a family member or a contact had tuberculosis disease?	NO	YES
Has a family member had a positive TB skin test (PPD)?	NO	YES
Was your child born in a high-risk country (countries other that the U.S., Canada, Australia, or Western Europe?	NO	YES
Has your child traveled to a high-risk country for more than a week?	NO	YES
Review of Systems		
Do you have any concerns about your child’s hearing?	NO	YES
Do you have any concerns about your child’s vision?	NO	YES