## M-CHAT

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/her 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 small toys (e.g. cars or blocks) 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 your child is deaf? | Yes No |
| 21. | Does your child understand what people say? | Yes No |
| 22. | Does your 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 |

# ATAQ

Asthma Therapy Assessment Questionnaire

Take a step toward control

Patient's name: _____

ID number: _____

Physician's name: _____ Date: _____

Physician: please have the parent or guardian complete this questionnaire.

**Instructions: Check 1 answer for each question and enter point value (0 or 1) on line.**

Control Issues — Enter Score

Other Issues — Enter Score

## PEDIATRIC/ADOLESCENT (5–17 YEARS OLD)

**1. In the *past 4 weeks*, did your child:**

| | | | | |
|---|---|---|---|---|
| a. Have wheezing or difficulty breathing when exercising? | ☐ Yes (1) | ☐ No (0) | ☐ Unsure (1) | Enter Score ____ |
| b. Have wheezing during the day when **not** exercising? | ☐ Yes (1) | ☐ No (0) | ☐ Unsure (1) | Enter Score ____ |
| c. Wake up at night with wheezing or difficulty breathing? | ☐ Yes (1) | ☐ No (0) | ☐ Unsure (1) | Enter Score ____ |
| d. Miss days of school because of his/her asthma? | ☐ Yes (1) | ☐ No (0) | ☐ Unsure (1) | Enter Score ____ |
| e. Miss any daily activities (such as playing, going to a friend's house, or any family activity) because of asthma? | ☐ Yes (1) | ☐ No (0) | ☐ Unsure (1) | Enter Score ____ |

**2. Does your child use an inhaler or a nebulizer for *quick relief* from asthma symptoms?*** ☐ Yes ☐ No ☐ Unsure

**If Yes,** In the **past 4 weeks**, what was the **greatest number of times in 1 day** your child used this inhaler/nebulizer?

| | | | | | |
|---|---|---|---|---|---|
| ☐ 0 | (0) | ☐ 3 to 4 | (1)* | ☐ More than 6 | (1) |
| ☐ 1 to 2 | (0) | ☐ 5 to 6 | (1)* | | |

Enter Score ____

*This reflects a lower threshold than was used in the ATAQ validation studies to identify potential control problems. This modification was designed to encourage patients and providers to discuss how asthma medications are being used.

**3. Has your child ever had a prescription for an asthma medicine that is NOT used for quick relief but is used to *control* his/her asthma?** ☐ Yes ☐ No ☐ Unsure

**If Yes,** Which statement best describes how you take this medicine now?

| | | | |
|---|---|---|---|
| ☐ Takes it every day. | (0) | ☐ Only takes it only when he/she has symptoms. | (1) |
| ☐ Takes it some days, but not other days. | (1) | ☐ Never takes it. | (1) |
| ☐ Used to take it, but now does not. | (1) | | |

Enter Score ____

**4. Are you dissatisfied with any part of your child's *current* asthma treatment?** ☐ Yes (1) ☐ No (0) ☐ Unsure (1) Enter Score ____

**5. Do you believe that:**

| | | | | |
|---|---|---|---|---|
| a. Your child's asthma was well controlled in the **past 4 weeks**? | ☐ Yes (0) | ☐ No (1) | ☐ Unsure (1) | Enter Score |
| b. Your child is able to take your asthma medicine(s) as directed? | ☐ Yes (0) | ☐ No (1) | ☐ Unsure (1) | Enter Score ____ |
| c. Your child's medicine(s) is useful in controlling his/her asthma? | ☐ Yes (0) | ☐ No (1) | ☐ Unsure (1) | Enter Score ____ |

**6. During this office visit, would you like your doctor to discuss:**

| | |
|---|---|
| ☐ Different types of drugs available to control asthma? | (1) |
| ☐ Your child's asthma treatment options? | (1) |
| ☐ How your child prefers to take his/her asthma medicine(s)? | (1) |
| ☐ Other issues? | (1) |

Enter Score ____

**Add the numbers in the light blue area and enter the total score here.** TOTAL ____

**Add the numbers in the dark blue area and enter the total score here.** TOTAL ____

**If either score is 1 or greater, discuss the questionnaire with your doctor.**



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# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

**Read entire document before signing**

Patient Name: _____ DOB: _____

1. I authorize the use or disclosure of the above named individual's health information described below.

2. The following individual(s) or organization(s) are authorized to make this disclosure:
   Name: _____
   Address: _____
   _____
   Phone: _____ Fax: _____

3. The information identified below may be disclosed to or used by the following individual(s) or organization(s):
   Name: _____
   Address: _____
   _____
   Phone: _____ Fax: _____

4. The type of information to be used or disclosed (requested) is as follows:

☐ Immunization Records ☐ Consultation Report (please supply name of consulting physician)
☐ Operative Report: Procedure _____ Date _____
☐ Progress Note(s): Date _____ or Range of Dates _____
☐ Psychotherapy Notes ☐ **Entire Record**
☐ Other (Please give specific description) _____

**SPECIAL AUTHORIZATION:**
I understand that my medical records may contain alcohol/drug abuse, HIV/hepatitis status, and/or mental health information and I give **special authorization** to the health care provider/facility to release this information in my records to the person, physician, facility named above for the stated purpose. I further understand that I may revoke this authorization in writing and I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

5. This information for which I am requesting disclosure will be used for the following purpose:

☐ My personal use ☐ To evaluate my eligibility for life insurance coverage
☐ Insurance (psychiatry) ☐ To evaluate my eligibility for disability benefits
☐ **Transferring** ☐ At the request of my attorney: Name _____
Reason for transferring _____
☐ Other (please describe) _____

6. **Re-disclosure.** I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization. This authorization will remain in effect from the date signed above until _____.**

_____ _____
**Signature of patient (or personal representative)** **Date**

_____ _____
**Name of Personal Representative (if applicable)** **Relationship to patient**