East Cobb Pediatrics & Adolescent Medicine, P.C.

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Parent Instructions for PEDS Form

- This form is a Parent's Evaluation of Developmental Status and helps to ensure that your child is progressing appropriately for their age.
- On the first question, please list any concerns that you have about your child. If you have no concerns, please write that on the form.
- For the remaining questions, answer *yes or A little* if you have the concern now or have had it in the past, even if it has improved. Please comment what the concern is or was.
- Answer No to the following questions if you have never had a concern about that question.
- Once completed, please give this form to the medical assistant or nurse that takes you back to the clinical area. If you have any questions, they will be happy to help you.

Thank you for completing the form.

Marietta: 1121 Johnson Ferry Road, Suite 220, Marietta, GA 30068 ph: 770-977-0094 fax: 770-509-9463
Kennesaw: 6110 Pine Mountain Road, Suite 202, Kennesaw, GA 30152 ph: 770-795-4553 fax: 770-795-4513

Visit us on the web: www.eastcobbpeds.com

To ACCURATELY score PEDS Providers MUST USE Score/Longitudinal Interpretation Forms and Brief Guide to Administration

PEDS RESPONSE FORM

_____
Provider

Child's Name _____ *Parent's Name* _____

Child's Birthday _____ *Child's Age* _____ *Today's Date* _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child understands what you say?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child uses his or her hands and fingers to do things?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child uses his or her arms and legs?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child behaves?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child gets along with others?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child is learning to do things for himself/herself?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child is learning preschool or school skills?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Please list any other concerns.

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#700PEDS1-2017

M CHAT

www.m-chat.org

Child's name _____ Date _____

D.O.B _____ 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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Georgia Healthy Homes and Lead Poisoning Prevention Program

Patients Name_____ Date of Birth_____

Risk Factors Assessment Questionnaire

1. Does your child live in or often visit a house that may have been built before 1978?

2. Does your child live in or often visit a house, built before 1978, that is being remodeled or is having paint removed?

3. Does your child live with or often visit another child that had or has an elevated blood lead level?

4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?

5. Does your child chew on or eat non-food items like paint chips or dirt?

6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

7. Does your child receive medicines such as greta, azarcon, kohl, or pay-loo-ah?

When using the questionnaire, blood lead tests should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

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