

1) Was your Child born in Africa, Asia, Latin America, the Caribbean or Eastern Europe?

Yes No

2) Has your child traveled to or lived in Africa, Asia, Latin America, the Caribbean or Eastern Europe for more than one week?

Yes No

3) Has your child been exposed to anyone with TB disease?

Yes No

4) Does your child have close contact or live with anyone who has had a positive TB skin test?

Yes No

5) Has your child spent time with anyone in the past 5 years who has been in a jail, shelter, uses illegal drugs, or has HIV?

Yes No

6) Has your child ever tested positive for HIV?

Yes No

7) Does your child have a household member who was born outside of the United States?

Yes No

8) Does your child have a household member who has traveled outside the United States?

Yes No

If Yes,

When:

Where:

1) Does your child live in or regularly visit a house that was built before 1950, including a home child care center or the home of a relative?

Yes No

2) Does your child live in or regularly visit a house built before 1978 that has been remodeled in the last 6 months?

Yes No

If No: Are their plans to remodel? Yes No

3) Does your child have a sibling, housemate, or playmate who is being treated for lead poisoning?

Yes No

4) Does your child live with an adult whose job or hobby involves exposure to lead?

Yes No

5) Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead into the environment?

Yes No

6) Does your child live within one block of a major highway or busy street?

Yes No

7) Has your child even been given home remedies such as azarcon, greta, or pay looah?

Yes No

8) Has your child ever lived outside of the United States?

Yes No

9) Does your family use pottery or ceramics for cooking, eating, or drinking?

Yes No

10) Have you seen your child eat paint chips?

Yes No

11) Have you seen your child eat soil or dirt?

Yes No

12) Have you been told your child has low iron?

Yes No

M-CHAT-R™

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.

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| 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 <u>unusual</u> 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 |