M-CHAT

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

Administered by: _____ Date: ___/___/___

Childhood Lead Risk Questionnaire

For assessing lead exposures in children.

Instructions: 1. Ask the child's parent or guardian the following questions and mark their responses.

2. If guardian answers **YES** or Don't Know (**D/K**) to any question, test the child for lead as soon as possible.

Child's Name: _____

Date of Birth: ___/___/___ **Age:** _____ years

Gender (circle one): **MALE** **FEMALE**

Provider's Name: _____

Please answer **YES**, Don't Know (**D/K**) or **NO** to the following questions:

	YES	D/K	NO
1. Does your child live in or visit homes, day care centers or other buildings built before 1978?	☐	☐	☐
2. Does your child live in or visit homes, day care centers or other buildings with recent repairs or remodeling	☐	☐	☐
3. Does your child eat or chew on non-food substances such as paint chips or dirt?	☐	☐	☐
4. Has anyone who lives in the same home as your child previously had an elevated blood lead level?	☐	☐	☐
5. Is your child a foreign adoptee, refugee or has your child recently travelled internationally?	☐	☐	☐
6. Does your child eat wild game such as moose, caribou or waterfowl that has been shot with lead bullets?	☐	☐	☐
7. Does your child come in contact with a person whose job or hobby includes any of the following:	☐	☐	☐

- Chemical preparation
- Valve and pipe fittings
- Brass/Copper foundry
- Refining furniture
- Making fishing weights
- Lead smelting
- Welding
- House construction or repair
- Battery manufacturing or repair
- Burning lead-painted wood
- Automotive repair shop or junk yard
- Going to a firing range or reloading bullets
- Radiator repairs
- Pottery making
- Mining
- Use of lead-containing aviation gas in airplanes or snow-machines

8. Does your family use foreign or traditional products such as imported pottery, health remedies, skin care creams, spices, or foods? These include:	☐	☐	☐

- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills or vitamins
- Traditional medicines such as ayurvedic, greta, azarcon, alarcon, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah and rueda
- Foods canned or packaged outside the U.S.

For more information, please contact:

Environmental Public Health Program, AKDHSS

(907) 269-8000

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