Childs Name: ____________________________ **Date:** _____________ **Provider Initials:** ________

Childhood Asthma Control Test: Children 12 years and above
Westwood Mansfield Pediatric Associates

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	None of the time (5)	SCORE: ☐

2. During the past **4 weeks**, how often have you had shortness of breath?

More than once a day (1)	Once a day (2)	3 to 6 times a week (3)	Once or twice a week (4)	Not at all (5)	☐

3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week (1)	2 or 3 nights a week (2)	Once a week (3)	Once or twice (4)	Not at all (5)	☐

4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day (1)	1 or 2 times per day (2)	2 or 3 times per week (3)	Once a week or less (4)	Not at all (5)	☐

5. How would you rate your **asthma** control during the past **4 weeks**?

Not controlled at all (1)	Poorly controlled (2)	Somewhat controlled (3)	Well controlled (4)	Completely controlled (5)	☐

Total ☐

In the past year has your child (please check all that apply):

- ☐ Been to an ER for asthma?
- ☐ Been hospitalized for asthma?
- ☐ Been treated with oral steroids (prednisone or prednisolone/orapred) for asthma?
- ☐ Been treated with an antibiotic for pneumonia, bronchitis, sinusitis?
- ☐ Missed school for asthma-related illness? If yes, number of days: _____

Does your home contain any of the following (please check all that apply):

- ☐ A smoker
- ☐ Carpet in your child's room
- ☐ Basement playroom
- ☐ Pets with hair
- ☐ Mold (or suspicion)
- ☐ Home older than 40 years
- ☐ Floor or ceiling heat vents
- ☐ Plants

Has your child ever been skin tested? ☐ Yes ☐ No

If yes, when? _________ If yes, what are his/her allergies? ______________________

In the past 14 days, how many doses of your medications have you missed? _________

Have any of your child's asthma medications caused side effects in your child? ☐ Yes ☐ No

Would you like a catalog of hypo allergen products for your home? ☐ Yes ☐ No

Do feel you have been able to follow your child's asthma plan? ☐ Yes ☐ No

Are you satisfied with your child's asthma management plan? ☐ Somewhat ☐ Yes ☐ No