

Childs Name: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Initials: \_\_\_\_\_

### Childhood Asthma Control Test: Children 4 to 11 years Westwood-Mansfield Pediatric Associates

Have your CHILD complete these questions:

1. How is your asthma today?

 0 Very bad	 1 Bad	 2 Good	 3 Very good	SCORE <input type="checkbox"/>
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2. How much of a problem is your asthma when you run, exercise or play sports?

 0 It's a big problem, I can't do what I want to do.	 1 It's a problem and I don't like it.	 2 It's a little problem but it's okay.	 3 It's not a problem.	<input type="checkbox"/>
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3. Do you cough because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.	<input type="checkbox"/>
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4. Do you wake up during the night because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.	<input type="checkbox"/>
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PARENTS please complete the following questions:

5. During the last 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?

5 Not at all	4 1-3 days/mo	3 4-10 days/mo	2 11-18 days/mo	1 19-24 days/mo	0 Everyday	<input type="checkbox"/>
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6. During the last 4 weeks, on average, how many days per month did your child wheeze during the day because of asthma?

5 Not at all	4 1-3 days/mo	3 4-10 days/mo	2 11-18 days/mo	1 19-24 days/mo	0 Everyday	<input type="checkbox"/>
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7. During the last 4 weeks, on average, how many days per month did your child wake up during the night because of asthma?

5 Not at all	4 1-3 days/mo	3 4-10 days/mo	2 11-18 days/mo	1 19-24 days/mo	0 Everyday	<input type="checkbox"/>
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TOTAL

Please turn over for additional questions.



**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
- Pets with hair
- Mold (or suspicion)
- Floor or ceiling heat vents
- Plants
- Basement playroom
- Home older than 40 years

**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