Patient Name: ______________________ Today's Date: ______________

Date of Birth: ______________________

Childhood Asthma Control Test for children 4 to 11 years.

This test will provide a score that may help the doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to the first four questions (1 to 4). If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining three questions (5 to 7) on your own and without letting your child's response influence your answers. There are no right or wrong answers.

Step 2 Write the number of each answer in the score box provided.

Step 3 Add up each score box for the total.

Step 4 Take the test to the doctor to talk about your child's total score.

19 or less If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. Bring this test to the doctor to talk about the results.

Have your child complete these questions.

1. How is your asthma today?

0	1	2	3	SCORE
Very bad	Bad	Good	Very good	

2. How much of a problem is your asthma when you run, exercise or play sports?

0	1	2	3	
It's a big problem, I can't do what I want to do.	It's a problem and I don't like it.	It's a little problem but it's okay.	It's not a problem.	

3. Do you cough because of your asthma?

0	1	2	3	
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.	

4. Do you wake up during the night because of your asthma?

0	1	2	3	
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.	

Please complete the following questions on your own.

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

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

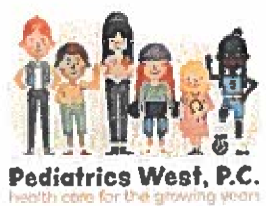
6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

TOTAL



ASTHMA DATA COLLECTION FORM

Parents – Please complete the following section:

1. Has your child visited the Emergency Room or Urgent Care due to **asthma** in the last 6 months?

   ☐ Yes ☐ No

2. Has your child been admitted to the hospital due to **asthma** in the last 6 months?

   ☐ Yes ☐ No

3. How many days of work have you and/or your partner missed due to your child's **asthma** in the last 6 months? ☐

4. How many days of school has your child missed due to **asthma** in the last 6 months? ☐

5. Does your child have frequent or seasonal allergy symptoms (running nose, nose rubbing, sneezing, itchy/watering eyes)? ☐ Yes ☐ No

6. Is your child prescribed a **daily controller asthma medication?**

   Examples of daily controller asthma medicines include: Advair, Asmanex, Budesonide, Dulera, Flovent, QVAR, Pulmicort, Singulair, Symbicort

   ☐ Yes (if Yes, go to 6a.) ☐ No (if No, go to 7.)

   a. How often do you **forget to give or miss** your child's **daily** controller asthma medicine?

      ☐ My child is not supposed to take a daily asthma medicine

      ☐ None of the time

      ☐ Some of the time 1-2 days/week

      ☐ Most of the time 3-4 days/week

      ☐ All of the time 5-7 days/week

7. Has your child received a flu vaccine (flu shot) in the last year?

   ☐ Yes ☐ No ☐ I don't know

   a. If yes, what date **(month and year)** did your child receive his/her flu vaccine? _____/_____

Please Take the Asthma Control Test ™

Total Score ☐

Asthma Control Test on other side of page