

ATAQ



Asthma Therapy Assessment Questionnaire*

Take a step toward control

Patient's name: _____

ID number: _____

Physician's name: _____ Date: _____

Physician: please have the parent or guardian complete this questionnaire.

Instructions: Check 1 answer for each question and enter point value (0 or 1) on line.

Control Issues	Other Issues
Enter score	Enter score

PEDIATRIC/ADOLESCENT (5-17 YEARS OLD)

1. In the past 4 weeks, did your child:

- | | | | | | |
|--|----------------------------------|---------------------------------|-------------------------------------|-------------|-------|
| a. Have wheezing or difficulty breathing when exercising? | <input type="checkbox"/> Yes (1) | <input type="checkbox"/> No (0) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |
| b. Have wheezing during the day when not exercising? | <input type="checkbox"/> Yes (1) | <input type="checkbox"/> No (0) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |
| c. Wake up at night with wheezing or difficulty breathing? | <input type="checkbox"/> Yes (1) | <input type="checkbox"/> No (0) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |
| d. Miss days of school because of his/her asthma? | <input type="checkbox"/> Yes (1) | <input type="checkbox"/> No (0) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |
| e. Miss any daily activities (such as playing, going to a friend's house, or any family activity) because of asthma? | <input type="checkbox"/> Yes (1) | <input type="checkbox"/> No (0) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |

2. Does your child use an inhaler or a nebulizer for quick relief from asthma symptoms?*

Yes No Unsure

If Yes, In the past 4 weeks, what was the greatest number of times in 1 day your child used this inhaler/nebulizer?

- | | | | | |
|-------------------------------------|--------------------------------------|--|-------------|-------|
| <input type="checkbox"/> 0 (0) | <input type="checkbox"/> 3 to 4 (1)* | <input type="checkbox"/> More than 6 (1) | Enter score | _____ |
| <input type="checkbox"/> 1 to 2 (0) | <input type="checkbox"/> 5 to 6 (1)* | | | |

*This reflects a lower threshold than was used in the ATAQ validation studies to identify potential control problems. This modification was designed to encourage patients and providers to discuss how asthma medications are being used.

3. Has your child ever had a prescription for an asthma medicine that is NOT used for quick relief but is used to control his/her asthma?

Yes No Unsure

If Yes, Which statement best describes how you take this medicine now?

- | | | | |
|--|---|-------------|-------|
| <input type="checkbox"/> Takes it every day. (0) | <input type="checkbox"/> Only takes it only when he/she has symptoms. (1) | Enter score | _____ |
| <input type="checkbox"/> Takes it some days, but not other days. (1) | <input type="checkbox"/> Never takes it. (1) | | |
| <input type="checkbox"/> Used to take it, but now does not. (1) | | | |

4. Are you dissatisfied with any part of your child's current asthma treatment?

Yes (1) No (0) Unsure (1) Enter score

5. Do you believe that:

- | | | | | | |
|--|----------------------------------|---------------------------------|-------------------------------------|-------------|-------|
| a. Your child's asthma was well controlled in the past 4 weeks? | <input type="checkbox"/> Yes (0) | <input type="checkbox"/> No (1) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |
| b. Your child is able to take your asthma medicine(s) as directed? | <input type="checkbox"/> Yes (0) | <input type="checkbox"/> No (1) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |
| c. Your child's medicine(s) is useful in controlling his/her asthma? | <input type="checkbox"/> Yes (0) | <input type="checkbox"/> No (1) | <input type="checkbox"/> Unsure (1) | Enter score | _____ |

6. During this office visit, would you like your doctor to discuss:

- | | | | |
|---|-----|-------------|-------|
| <input type="checkbox"/> Different types of drugs available to control asthma? | (1) | Enter score | _____ |
| <input type="checkbox"/> Your child's asthma treatment options? | (1) | | |
| <input type="checkbox"/> How your child prefers to take his/her asthma medicine(s)? | (1) | | |
| <input type="checkbox"/> Other issues? | (1) | | |

Add the numbers in the light blue area and enter the total score here.

TOTAL _____

Add the numbers in the dark blue area and enter the total score here.

TOTAL _____

If either score is 1 or greater, discuss the questionnaire with your doctor.