

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

### 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?

- 0 (0)  1 to 2 (0)  3 to 4 (1)\*  5 to 6 (1)\*  More than 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, parents or guardians, 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 your child takes this medicine now?

- Takes it every day (0)  Only takes it only when he/she has symptoms (1)  
 Takes it some days, but not other days (1)  Never takes it (1)  
 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)

### 5. Do you believe that:

- a. Your child's asthma was well controlled in the past 4 weeks?  Yes (0)  No (1)  Unsure (1)
- b. Your child is able to take asthma medicine(s) as directed?  Yes (0)  No (1)  Unsure (1)
- c. Your child's medicine(s) is useful in controlling his/her asthma?  Yes (0)  No (1)  Unsure (1)

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

- Different types of drugs available to control asthma? (1)
- Your child's asthma treatment options? (1)
- How your child prefers to take his/her asthma medicine(s)? (1)
- 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.