

asthma control test

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

FOR PATIENTS:

Take the Asthma Control Test™ (ACT) for people 12 years and older.

Know your score. Share your results with your doctor.

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for your total.

Step 3 Take the test to your doctor to talk about your score.

Score

- | | | |
|----------|---|----------------------|
| 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 home?
1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time | <input type="text"/> |
| 2 | During the past 4 weeks, how often have you had shortness of breath?
1. More than once a day 2. Once a day 3. 3 to 6 times a week 4. Once or twice a week 5. Not at all | <input type="text"/> |
| 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?
1. 4 or more nights a week 2. 2 or 3 nights a week 3. Once a week 4. Once or twice 5. Not at all | <input type="text"/> |
| 4 | During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?
1. 3 or more times per day 2. 1 or 2 times per day 3. 2 or 3 times per week 4. Once a week or less 5. Not at all | <input type="text"/> |
| 5 | How would you rate your asthma control during the past 4 weeks?
1. Not controlled at all 2. Poorly controlled 3. Somewhat controlled 4. Well controlled 5. Completely controlled | <input type="text"/> |

If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.

Total

FOR PHYSICIANS:

The ACT is:

A simple, 5-question tool that is self-administered by the patient

Clinically validated by specialist assessment and spirometry

Recognized by the National Institutes of Health

Childhood asthma control test for children ages 4 to 11 years old

know the score.

This test will provide a score that may help your 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.

Score

have your child complete these questions.

<p>1 How is your asthma today?</p>	 0. Very bad	 1. Bad	 2. Good	 3. Very Good	<input style="width: 30px; height: 30px;" type="text"/>
<p>2 How much of a problem is your asthma when you run, exercise or play sports?</p>	 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 style="width: 30px; height: 30px;" type="text"/>
<p>3 Do you cough because of your asthma?</p>	 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 style="width: 30px; height: 30px;" type="text"/>
<p>4 Do you wake up during the night because of your asthma?</p>	 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 style="width: 30px; height: 30px;" type="text"/>

please complete the following questions on your own.

<p>5 During the last 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?</p>	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 style="width: 30px; height: 30px;" type="text"/>
<p>6 During the last 4 weeks, on average, how many days per month did your child wheeze during the day because of asthma?</p>	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 style="width: 30px; height: 30px;" type="text"/>
<p>7 During the last 4 weeks, on average, how many days per month did your child wake up during the night because of asthma?</p>	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 style="width: 30px; height: 30px;" type="text"/>

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. No matter what the score, bring this test to your doctor to talk about your child's results.

Total