Asthma Control Test (ACT) for people 13 yrs. and older.

Child's Name: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best describes you:

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 at home?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time
2. During the past **4 weeks**, how often have you had shortness of breath?	☐ More than once a day	☐ Once a day	☐ 3 to 6 times a week	☐ Once or twice a week	☐ Not at all
3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, and shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	☐ 4 or more nights a week	☐ 2 or 3 nights a week	☐ Once a week	☐ Once or twice	☐ Not at all
4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	☐ 3 or more times per day	☐ 1 or 2 times per day	☐ 2 or 3 times per week	☐ Once a week or less	☐ Not at all
5. How would you rate your **asthma** control during the past **4 weeks**?	☐ Not controlled at all	☐ Poorly controlled	☐ Somewhat controlled	☐ Well controlled	☐ Completely controlled