

Asthma Control Test (ACT) - 4 to 12 Years

Child's Name: _____

Date of Birth: _____ Today's Date: _____

Have your child complete these questions.

1. How is your asthma today?	<input type="checkbox"/> Very Bad	<input type="checkbox"/> Bad	<input type="checkbox"/> Good	<input type="checkbox"/> Very Good
2. How much of a problem is your asthma when you run, exercise or play sports?	<input type="checkbox"/> It's a big problem, I can't do what I want to do.	<input type="checkbox"/> It's a problem and I don't like it.	<input type="checkbox"/> It's a little problem but it's okay.	<input type="checkbox"/> It's not a problem.
3. Do you cough because of your asthma?	<input type="checkbox"/> Yes, all of the time.	<input type="checkbox"/> Yes, most of the time.	<input type="checkbox"/> Yes, some of the time.	<input type="checkbox"/> No, none of the time
4. Do you wake up during the night because of your asthma?	<input type="checkbox"/> Yes, all of the time.	<input type="checkbox"/> Yes, most of the time.	<input type="checkbox"/> Yes, some of the time.	<input type="checkbox"/> 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?**

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?**

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?**

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