

OMB CONTROL NUMBER: 0704-XXXX

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**ASQ-3 2-Month Version**

Please provide the following information.

Date ASQ Completed (MM/DD/YYYY):

\_\_\_\_\_

Baby's date of birth: \_\_\_\_\_

If baby was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please select the response that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

**Important Points to Remember:**

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Does your baby sometimes make throaty or gurgling sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. When you speak to your baby, does she make sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your baby smile when you talk to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. After you have been out of sight, does your baby smile or get excited when she sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**GROSS MOTOR**

	YES	SOMETIMES	NOT YET
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- |   |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|
| 2. When your baby is on her tummy, does she turn her head to the side?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. When your baby is on his tummy, does he hold his head up longer than a few seconds?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. When your baby is on her back, does she kick her legs?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. While your baby is on his back, does he move his head from side to side?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**FINE MOTOR**

	YES	SOMETIMES	NOT YET
1. Is your baby's hand usually tightly closed when he is awake? (If your baby used to do this but no longer does, mark "YES")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your baby grasp your finger if you touch the palm of her hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. When you put a toy in his hand, does your baby hold it in his hand briefly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your baby touch her face with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

her hands?

5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)?

6. Does your baby grab or scratch at her clothes?

**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. Does your baby look at objects that are 8-10 inches away?

2. When you move around, does your baby follow you with his eyes?

3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head?

4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?

5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or

rattle) that you place on the table or floor in front of her?

6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy?

**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. Does your baby sometimes try to suck, even when she's not feeding?

2. Does your baby cry when he is hungry, wet, tired, or wants to be held?

3. Does your baby smile at you?

4. When you smile at your baby, does she smile back?

5. Does your baby watch his hands?

6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?

**OVERALL**

1. Did your baby pass the newborn hearing screening test? If no, explain.

Yes

No \_\_\_\_\_

2. Does your baby move both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain.

Yes \_\_\_\_\_

No

4. Has your baby had any medical problems? If yes, explain.

Yes \_\_\_\_\_

No

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain.

Yes \_\_\_\_\_

No

6. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 4-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Baby's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If baby was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please click in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

**Important Points to Remember:**

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. After you have been out of sight, does your baby smile or get excited when	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



he sees you?

3. Does your baby stop crying when she hears a voice other than yours?

4. Does your baby make high-pitched squeals?

5. Does your baby laugh?

6. Does your baby make sounds when looking at toys or people?

**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. While your baby is on his back, does he move his head from side to side?

2. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?

3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?

4. When your baby is on her tummy, does she hold her head straight up, looking around? (She can rest her arms while doing this.)

5. When you hold him in a sitting position, does your baby hold his head steady?

6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers?

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)?

2. When you put a toy in her hand, does your baby wave it about, at least briefly?

3. Does your baby grab or scratch at his clothes?

4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?

5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?

6. When you hold your baby in a sitting

position, does she reach for a toy on a table close by, even though her hand may not touch it?

**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET
1. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. When you put a toy in her hand, does your baby look at it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. When you put a toy in his hand, does your baby put the toy in his mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When you dangle a toy above your baby while she is lying on her back, does your baby wave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

her arms toward the toy?

**PERSONAL-SOCIAL**

	YES	SOMETIMES	NOT YET
1. Does your baby watch his hands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. When your baby has her hands together, does she play with her fingers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Before you smile or talk to your baby, does he smile when he sees you nearby?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When in front of a large mirror, does your baby smile or coo at herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**OVERALL**

1. Does your baby use both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain.

Yes

No \_\_\_\_\_

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain.

Yes \_\_\_\_\_

No

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

5. Do you have concerns about your baby's vision? If yes, explain.

Yes \_\_\_\_\_

No

6. Has your baby had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your baby's behavior? If yes, explain.

Yes \_\_\_\_\_

No

8. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 6-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Baby's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If baby was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need? (e.g., autism, speech delay)

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please click in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. When playing with sounds, does your baby make grunting,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

growling, or other deep-toned sounds?

3. If you call your baby when you are out of sight, does she look in the direction of your voice?

4. When a loud noise occurs, does your baby turn to see where the sound came from?

5. Does your baby make sounds like "da," "ga," "ka," and "ba"?

6. If you copy the sound your baby makes, does your baby repeat the same sounds back to you?

**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. While your baby is on his back, does your baby lift his legs high enough to see his feet?

2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?

3. Does your baby roll from his back to his tummy, getting both arms out from under him?

4. When you put your baby on the floor, does she lean on her



hands while sitting?  
 (If she already sits up  
 straight without  
 leaning on her  
 hands, mark "YES"  
 for this item.)

5. If you hold both  
 hands just to balance  
 your baby, does he  
 support his own  
 weight while  
 standing?

6. Does your baby  
 get into a crawling  
 position by getting up  
 on her hands and  
 knees?







**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your baby  
 grab a toy you offer  
 and look at it, wave it  
 about, or chew on it  
 for about 1 minute?




2. Does your baby  
 reach for or grasp a  
 toy using both hands  
 at once?




3. Does your baby  
 reach for a crumb or  
 Cheerio and touch it  
 with his finger or  
 hand? (If he already  
 picks up a small  
 object the size of a  
 pea, mark "YES" for  
 this item.)




4. Does your baby  
 pick up a small toy,  
 holding it in the  
 center of her hand  
 with her fingers  
 around it?

5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? (If he already picks up the crumb or Cheerio, mark "YES" for this item.)




6. Does your baby pick up a small toy with only one hand?




**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. When a toy is in front of your baby, does she reach for it with both hands?




2. When your baby is on his back, does he turn his head to look for a toy when he drops it? (If he already picks it up, mark "YES" for this item.)




3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?




4. Does your baby pick up a toy and put it in his mouth?




5. Does your baby pass a toy back and forth from one hand to the other?




6. Does your baby play by banging a toy up and down on the

floor or table?

**PERSONAL-SOCIAL**

	YES	SOMETIMES	NOT YET
1. When in front of a large mirror, does your baby smile or coo at herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your baby act differently toward strangers than he does with you and other familiar people? (Reactions to strangers may include staring, frowning, withdrawing, or crying.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. While lying on her back, does your baby play by grabbing her foot?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. When in front of a large mirror, does your baby reach out to pat the mirror?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. While your baby is on his back, does he put his foot in his mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does your baby try to get a toy that is out of reach? (She may roll, pivot on her tummy, or crawl to get it.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**OVERALL**

1. Does your baby use both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain.

Yes

No \_\_\_\_\_

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain.

Yes \_\_\_\_\_

No

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

5. Do you have concerns about your baby's vision? If yes, explain.

Yes \_\_\_\_\_

No

6. Has your baby had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your baby's behavior? If yes, explain.

Yes \_\_\_\_\_

No

8. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken (check all that apply):**

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 8-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Baby's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If baby was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need? (e.g., autism, speech delay)

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please click in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. If you call to your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. When a loud noise occurs, does your baby turn to see where the sound came from?

3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?

4. Does your baby make sounds like "da," "ga," "ka," and "ba"?

5. Does your baby respond to the tone of your voice and stop his activity at least briefly when you say "no-no" to him?

6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)

**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. When you put your baby on the floor, does she lean on her hands while sitting? (If she already sits up straight without leaning on her hands, mark "YES" for this item.)

2. Does your baby roll from his back to his tummy, getting both arms out from under him?

3. Does your baby get into a crawling position by getting up on her hands and knees?




4. If you hold both hands just to balance your baby, does he support his own weight while standing?




5. When sitting on the floor, does your baby sit up straight for several minutes without using her hands for support?




6. When you stand your baby next to furniture or the crib rail, does he hold on without leaning his chest against the furniture for support?




**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? (If she already picks up a small object mark "YES" for this item.)




2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?




3. Does your baby try to pick up a crumb or Cheerio by using her



thumb and all of her fingers in a raking motion, even if she isn't able to pick it up? (If she already picks up a crumb or Cheerio, mark "YES" for this item.)

4. Does your baby pick up a small toy with only one hand?




5. Does your baby successfully pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion? (If he already picks up a crumb or Cheerio, mark "YES" for this item).




6. Does your baby pick up a small toy with the tips of her thumb and fingers? (You should see a space between the toy and her palm.)




**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. Does your baby pick up a toy and put it in his mouth?




2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?




3. Does your baby play by banging a toy up and down on the floor or table?




4. Does your baby pass a toy back and

forth from one hand to the other?

5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?

6. When holding a toy in his hand, does your baby bang it against another toy on the table?

**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. When lying on her back, does your baby play by grabbing her foot?

2. When in front of a large mirror, does your baby reach out to pat the mirror?

3. Does your baby try to get a toy that is out of reach? (He may roll, pivot on his tummy, or crawl to get it.)

4. While your baby is on her back, does she put her foot in her mouth?

5. Does your baby drink water, juice, or formula from a cup while you hold it?

6. Does your baby feed himself a cracker or a cookie?

**OVERALL**

1. Does your baby use both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain.

Yes

No \_\_\_\_\_

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain.

Yes \_\_\_\_\_

No

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

5. Do you have concerns about your baby's vision? If yes, explain.

Yes \_\_\_\_\_

No

6. Has your baby had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your baby's behavior? If yes, explain.

Yes \_\_\_\_\_

No

8. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 9-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Baby's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If baby was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please click in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?

3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)

4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peekaboo," "clap your hands," "So Big")?

5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?

6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)

**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. If you hold both hands just to balance your baby, does she support her own

weight while standing?

2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?

3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?

4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?

5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?

6. Does your baby walk beside furniture while holding on with only one hand?

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your baby pick up a small toy with only one hand?

2. Does your baby successfully pick up a crumb or Cheerio by using her thumb

and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "YES" for this item.)

3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)

4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)

5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.

6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?

**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. Does your baby pass a toy back and forth from one hand to the other?

2. Does your baby pick up two small toys, one in each hand, and hold onto



them for about 1 minute?

3. When holding a toy in his hand, does your baby bang it against another toy on the table?

4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?

5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?

6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)

**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. While your baby is on her back, does she put her foot in her mouth?

2. Does your baby drink water, juice, or formula from a cup while you hold it?

3. Does your baby feed himself a cracker or a cookie?

4. When you hold out your hand and ask

for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "YES" for this item.)

5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?

6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?

**OVERALL**

1. Does your baby use both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain.

Yes

No \_\_\_\_\_

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain.

Yes \_\_\_\_\_

No

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

5. Do you have concerns about your baby's vision? If yes, explain.

Yes \_\_\_\_\_

No

6. Has your baby had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your baby's behavior? If yes, explain.

Yes \_\_\_\_\_

No

8. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 10-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

---

Baby's date of birth (MM/DD/YYYY):

---

If baby was born 3 or more weeks prematurely, # of weeks premature:

---

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please click in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. If you copy the sounds your baby	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

makes, does your baby repeat the same sounds back to you?

3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)

4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peekaboo," "clap your hands," "So Big")?

5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?

6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)













**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. If you hold both hands just to balance your baby, does she support her own weight while standing?

2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?




3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?




4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?




5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?




6. Does your baby walk beside furniture while holding on with only one hand?




**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your baby pick up a small toy with only one hand?




2. Does your baby successfully pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "YES")

for this item.)

3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)

4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)

5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.

6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?

**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. Does your baby pass a toy back and forth from one hand to the other?

2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?

3. When holding a toy in his hand, does



your baby bang it against another toy on the table?

4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?

5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?

6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)

**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. While your baby is on her back, does she put her foot in her mouth?

2. Does your baby drink water, juice, or formula from a cup while you hold it?

3. Does your baby feed himself a cracker or a cookie?

4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the

toy into your hand, mark "YES" for this item.)

5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?

6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?

### OVERALL

1. Does your baby use both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain.

Yes

No \_\_\_\_\_

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain.

Yes \_\_\_\_\_

No

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

5. Do you have concerns about your baby's vision? If yes, explain.

Yes \_\_\_\_\_

No

6. Has your baby had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your baby's behavior? If yes, explain.

Yes \_\_\_\_\_

No

8. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken tat this time.

Other (specify): \_\_\_\_\_

**ASQ-3 12-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Baby's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If baby was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please click in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peekaboo," "clap your hands," "So Big")?

3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?

4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)

5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "YES" if she knows one object.)

6. When your baby wants something, does he tell you by pointing to it?

**GROSS MOTOR**

YES                      SOMETIMES                      NOT YET

1. While holding onto furniture, does your baby bend down and pick up a toy from the

floor and then return to a standing position?

2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?

3. Does your baby walk beside furniture while holding on with only one hand?

4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "YES" for this item.)

5. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "YES" for this item.)

6. Does your baby stand up in the middle of the floor by himself and take several steps forward?

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? (The string may be

attached to a toy.)

2. Does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? She may rest her arm or hand on the table while doing it.

3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?

4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger?

5. Does your baby throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)

6. Does your baby help turn the pages of a book? (You may lift a page for him to grasp.)

**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?



2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?

3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)

4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? (If she already lets go of the toy into a bowl or box, mark "YES" for this item.)

5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? (You may show him how to do it.)

6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? (If she already scribbles on her own, mark "YES" for this item.)

**PERSONAL-SOCIAL**

YES                      SOMETIMES                      NOT YET

1. When you hold out your hand and ask

for his toy, does your baby offer it to you even if he doesn't let go of it? (If he already lets go of the toy into your hand, mark "YES" for this item.)

2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve?

3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand?

4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg?

5. Does your baby roll or throw a ball back to you so that you can return it to him?

6. Does your baby play with a doll or stuffed animal by hugging it?

**OVERALL**

1. Does your baby use both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

2. Does your baby play with sounds or seem to make words? If no, explain.

Yes

No \_\_\_\_\_

3. When your baby is standing, are her feet flat on the surface most of the time? If no, explain.

Yes

No \_\_\_\_\_

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain.

Yes \_\_\_\_\_

No

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have concerns about your baby's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your baby had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your baby's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

- Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_
- Share results with primary health care provider.
- Refer for hearing screening.
- Refer for vision screening.
- Refer for behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time.
- Other (specify): \_\_\_\_\_

**ASQ-3 14-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Baby's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If baby was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Baby's sex

Male

Female

Does the baby have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please click in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your baby more than one time. If possible, try the activities when your baby is cooperative. If your baby can do the activity but refuses, mark "YES" for the item.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET

1. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. When your baby wants something, does she tell you by pointing to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your baby shake his head when he means "no" or "yes"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your baby point to, pat, or try to pick up pictures in a book?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your baby say four or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When you ask her to, does your baby go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**GROSS MOTOR**

	YES	SOMETIMES	NOT YET
1. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "YES" for this	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

item.)

2. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "YES" for this item.)

3. Does your baby stand up in the middle of the floor by himself and take several steps forward?

4. Does your baby climb onto furniture or other large objects, such as large climbing blocks?

5. Does your baby bend over or squat to pick up an object from the floor and then stand up again without any support?

6. Does your baby move around by walking, rather than by crawling on his hands and knees?

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger?

2. Does your baby throw a small ball

with a forward arm motion? (If he simply drops the ball, mark "NOT YET" for this item.)

3. Does your baby help turn the pages of a book? (You may lift a page for her to grasp.)

4. Does your baby stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

5. Does your baby make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?

6. Does your baby stack three small blocks or toys on top of each other by herself?

**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although he may not let go of it? (If he already lets go of the toy into a bowl or box, mark "YES" for this item.)



2. Does your baby drop two small toys, one after the other, into a container like a bowl or box? (You may show her how to do it.)

3. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? (If he already scribbles on his own, mark "YES" for this item.)

4. Can your baby drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?

5. Does your baby drop several small toys, one after another, into a container like a bowl or box? (You may show her how to do it.)

6. After you have shown your baby how, does he try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?

**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg?

2. Does your baby roll or throw a ball back to you so that you can return it to him?

3. Does your baby play with a doll or stuffed animal by hugging it?

4. Does your baby feed herself with a spoon, even though she may spill some food?

5. Does your baby help undress himself by taking off clothes like socks, hat, shoes, or mittens?

6. Does your baby get your attention or try to show you something by pulling on your hand or clothes?

### OVERALL

1. Does your baby use both hands and both legs equally well? If no, explain.

Yes

No \_\_\_\_\_

2. Does your baby play with sounds or seem to make words? If no, explain.

Yes

No \_\_\_\_\_

3. When your baby is standing, are her feet flat on the surface most of the time? If no, explain.

Yes

No \_\_\_\_\_

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain.

Yes \_\_\_\_\_

No

5. Does either parent have a history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have concerns about your baby's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your baby had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your baby's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your baby worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

- Share results with primary health care provider.
- Refer for hearing screening.
- Refer for vision screening.
- Refer for behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time.
- Other (specify): \_\_\_\_\_

**ASQ-3 16-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If child was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "YES" for the item.

**COMMUNICATION**

YES

SOMETIMES

NOT YET

\_\_\_\_\_

- |   |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|
| 1. Does your child point to, pat, or try to pick up pictures in a book?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Does your child say four or more words in addition to "Mama" and "Dada"?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. When your child wants something, does she tell you by pointing to it?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "YES" even if her words are difficult to understand.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Does your child say eight or more words in addition to "Mama" and "Dada"?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child stand up in the middle of the floor by himself and take several steps forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child climb onto furniture or other large objects, such as large climbing blocks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your child move around by walking, rather than crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**FINE MOTOR**

	YES	SOMETIMES	NOT YET
1. Does your child help turn the pages of a book? (You may lift a page for her to grasp.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, mark "NOT YET" for this item.)




3. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)




4. Does your child stack three small blocks or toys on top of each other by herself?




5. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?




6. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)




**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. After you scribble back and forth on paper with a crayon (or pencil or pen), does your child copy you by scribbling? (If she already scribbles on her own, mark "YES" for this item.)



2. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?

3. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.)

4. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?

5. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?

6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump it out? (You may show her how.)

**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. Does your child feed himself with a spoon, even though he may spill some food?

2. Does your child help undress herself by taking off clothes like socks, hat, shoes, or mittens?

3. Does your child play with a doll or stuffed animal by hugging it?

4. While looking at himself in the mirror, does your child offer a toy to his own image?

5. Does your child get your attention or try to show you something by pulling on your hand or clothes?

6. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?

**OVERALL**

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Do you think your child walks, runs, and climbs like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): (1) \_\_\_\_\_

- Share results with primary health care provider. (2)
- Refer for hearing screening. (3)
- Refer for vision screening. (4)
- Refer for behavioral screening. (5)
- Refer to primary health care provider or other community agency (specify reason): (6) \_\_\_\_\_
- Refer to early intervention/early childhood special education. (7)
- No further action taken at this time. (8)
- Other (specify): (9) \_\_\_\_\_

**ASQ-3 18-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If child was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "YES" for the item.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. When your child wants something, does she tell you by	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

pointing to it?

2. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")

3. Does your child say eight or more words in addition to "Mama" and "Dada"?

4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "YES" even if her words are difficult to understand.)

5. Without your showing him, does your child point to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)

6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't

count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")

**GROSS MOTOR**

	YES	SOMETIMES	NOT YET
1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child move around by walking, rather than by crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

forward or by walking into it? (If your child already kicks a ball, mark "YES" for this item.)

**FINE MOTOR**

	YES	SOMETIMES	NOT YET
1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, mark "NOT YET" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your child stack three small blocks or toys on top of each other by himself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET
1. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "NOT YET" if your child scribbles back and forth.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.)




**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. While looking at herself in the mirror, does your child offer a toy to her own image?




2. Does your child play with a doll or stuffed animal by hugging it?




3. Does your child get your attention or try to show you something by pulling on your hand or clothes?




4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar?




5. Does your child drink from a cup or glass, putting it down again with little spilling?




6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

**OVERALL**

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Do you think your child walks, runs, and climbs like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 20-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If child was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "YES" for the item.

**COMMUNICATION**

YES

SOMETIMES

NOT YET

\_\_\_\_\_

1. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "YES" even if her words are difficult to understand.)

2. Does your child say eight or more words in addition to "Mama" and "Dada"?

3. Without your showing him, does your child point to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)

4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly name at least one picture?

5. Without your giving him clues by pointing or using gestures, can your child carry out at least three of these kinds of directions?

- a. "Put the toy on the table."
- b. "Close the door."
- c. "Bring me a towel."

d. "Find your coat."

e. "Take my hand."

f. "Get your book."

6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")

**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?

2. Does your child walk well and seldom fall?

3. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)

4. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "YES" for this item.)

5. Does your child run fairly well, stopping herself without bumping into things or falling?

6. Does your child walk either up or down at least two steps by himself? He may also hold onto the railing or wall.

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?

2. Does your child stack three small blocks or toys on top of each other by herself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

3. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)



4. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?

5. Does your child stack six small blocks or toys on top of each other by himself?

6. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?

2. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "NOT YET" if your child scribbles back and forth.)

3. If you do any of the following gestures, does your child copy at least one of them?  
a. Open and close



clothes?

3. Does your child drink from a cup or glass, putting it down again with little spilling?

4. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

5. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?

6. Does your child eat with a fork?

**OVERALL**

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have any concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

- Refer for vision screening.
- Refer for behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time.
- Other (specify): \_\_\_\_\_

**ASQ-3 22-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

If child was born 3 or more weeks prematurely, # of weeks premature:

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "YES" for the item.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. If you point to a picture of a ball (kitty, cup, hat, etc.) and	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ask your child, "What is this?" does your child correctly name at least one picture?

2. Without your giving him clues by pointing or using gestures, can your child carry out at least three of these kinds of directions?

- a. "Put the toy on the table."
- b. "Close the door."
- c. "Bring me a towel."
- d. "Find your coat."
- e. "Take my hand."
- f. "Get your book."

3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll. Mark "SOMETIMES" if she correctly points to at least three different body parts.)

4. Does your child say 15 or more words in addition to "Mama" and "Dada"?

5. Does your child correctly use at least two words like "me," "I," "mine," and "you"?

6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy

come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")

**GROSS MOTOR**

	YES	SOMETIMES	NOT YET
1. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "YES" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your child walk down stairs if you hold onto one of his hands? He may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?




**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?




2. Does your child stack six small blocks or toys on top of each other by himself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)




3. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?




4. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)




5. Does your child flip switches off and on?




6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET
1. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up at least two blocks side by side? (You can also use spools of thread, small boxes, or other toys.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your child pretend objects are something else? For example, does your child hold a cup to his ear, pretending it is a telephone? Does he put a box on his head, pretending it is a hat? Does he use a block or small toy to stir food?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "NOT YET" if your child scribbles back and forth.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. After a crumb or Cheerio is dropped	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?

6. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?

**OVERALL**

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 24-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

---

Child's date of birth (MM/DD/YYYY):

---

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "YES" for the item.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Without your showing him, does your child point to the correct picture when you say, "Show me the kitty," or ask,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"Where is the dog?"

(She needs to identify only one picture correctly.)

2. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "YES" even if her words are difficult to understand.)

3. Without your giving him clues by pointing or using gestures, can your child carry out at least three of these kinds of directions?  
a. "Put the toy on the table."  
b. "Close the door."  
c. "Bring me a towel."  
d. "Find your coat."  
e. "Take my hand."  
f. "Get your book."

4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly name at least one picture?

5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word



combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")

6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?




**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)




2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "YES" for this item.)




3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.




4. Does your child run fairly well, stopping herself without bumping into things or falling?

5. Does your child jump with both feet leaving the floor at the same time?

6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?

2. Does your child turn the pages of a book by herself? (She may turn more than one page at a time.)

3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

4. Does your child flip switches off and on?

5. Does your child stack seven small blocks or toys on top of each other by herself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "NOT YET" if your child scribbles back and forth.)

2. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.) (You can use a soda-pop bottle or baby bottle.)

3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?

4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?

5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or "help" you in the kitchen)?

6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up four objects in a row? (You can also use spools of thread, small boxes, or other toys.)

**PERSONAL-SOCIAL**

YES                      SOMETIMES                      NOT YET

1. Does your child drink from a cup or glass, putting it down again with little spilling?

2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

3. Does your child eat with a fork?

4. When playing with either a stuffed animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?

5. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?

6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."

**OVERALL**

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have any concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

- Refer for vision screening.
- Refer for behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time.
- Other (specify): \_\_\_\_\_

**ASQ-3 27-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "YES" for the item.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. Without your giving him clues by pointing or using gestures, can your child carry out at	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



least three of these kinds of directions?

- a. "Put the toy on the table."
- b. "Close the door."
- c. "Bring me a towel."
- d. "Find your coat."
- e. "Take my hand."
- f. "Get your book."

2. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly name at least one picture?

3. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll. Mark "SOMETIMES" if she correctly points to at least three different body parts.)

4. Does your child correctly use at least two words like "me," "I," "mine," and "you"?

5. Does your child make sentences that are three or four words long?

6. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the

chair." Does your child carry out both of these directions correctly?

**GROSS MOTOR**

	YES	SOMETIMES	NOT YET
1. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your child jump forward at least 3 inches with both feet leaving the ground at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

wall.

**FINE MOTOR**

	YES	SOMETIMES	NOT YET
1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child flip switches off and on?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your child stack seven small blocks or toys on top of each other by herself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. After your child watches you draw a line from one side of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?

**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET
<p>1. Does your child pretend objects are something else? For example, does your child hold a cup to his ear, pretending it is a telephone? Does he put a box on his head, pretending it is a hat? Does he use a block or small toy to stir food?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>2. Does your child put things away where they belong? For example, does she know her toys belong on the toy shelf, her blanket goes on her bed, and dishes go in the kitchen?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>3. When looking in the mirror, ask "Where is _____?" (Use your child's name.) Does your child point to his image in the mirror?</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>4. If your child wants something she cannot reach, does she find a chair or box to stand on to</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?

5. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up four objects in a row? (You can also use spools of thread, small boxes, or other toys.)

6. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "YES" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")

**PERSONAL-SOCIAL**

YES                      SOMETIMES                      NOT YET

1. If you do any of the following gestures, does your child copy at least one of them?  
 a. "Open and close your mouth."  
 b. "Blink your eyes."  
 c. "Pull on your earlobe."  
 d. "Pat your cheek."

2. Does your child eat with a fork?

3. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?

4. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?

5. Does your child call herself "I" or "me" more often than her own name? For example, "I do it" more often than "Juanita do it."

6. Does your child put on a coat, jacket, or shirt by himself?

**OVERALL**

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes (1)

No (2) \_\_\_\_\_

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

6. Do you have concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

7. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

8. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

9. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

- Share results with primary health care provider.
- Refer for hearing screening.
- Refer for vision screening.
- Refer for behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time.
- Other (specify): \_\_\_\_\_



**ASQ-3 30-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly name at least one picture?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Without your giving him clues by pointing or using gestures, can your child carry out at least three of these kinds of directions?

- a. "Put the toy on the table."
- b. "Close the door."
- c. "Bring me a towel."
- d. "Find your coat."
- e. "Take my hand."
- f. "Get your book."

3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least seven body parts?

(She can point to parts of herself, you, or a doll. Mark "SOMETIMES" if she correctly points to at least three different body parts.)

4. Does your child make sentences that are three or four words long?

5. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?

6. When looking at a picture book, does your child tell you what is happening or what action is taking

place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"

**GROSS MOTOR**

	YES	SOMETIMES	NOT YET
1. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or wall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Does your child stand on one foot for about 1 second without holding onto anything?

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?

3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

4. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?

5. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?




6. Does your child turn pages in a book, one page at a time?




**PROBLEM SOLVING**

YES

SOMETIMES

NOT YET

1. When looking in the mirror, ask, "Where is \_\_\_\_\_?" (Use your child's name.) Does your child point to her image in the mirror?




2. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?




3. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up four objects in a row? (You can also use spools of thread, small boxes, or other toys.)




4. When you point to the figure and ask your child, "What is

this?" does your child say a word that means a person or something similar? (Mark "YES" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")

5. When you say, "Say 'seven three,'" does your child repeat just the two numbers in the same order?

Do not repeat the numbers. If necessary, try another pair of numbers and say, "Say 'eight two.'"

Your child must repeat just one series of two numbers for you to answer "YES" to this question.

6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? (You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)







**PERSONAL-SOCIAL**

YES

SOMETIMES

NOT YET

1. If you do any of the following gestures, does your child copy at least one of them?

- a. "Open and close your mouth."
- b. "Blink your eyes."
- c. "Pull on your earlobe."
- d. "Pat your cheek."

2. Does your child use a spoon to feed himself with little spilling?

3. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?

4. Does your child put on a coat, jacket, or shirt by himself?

5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?

6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?

### OVERALL

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Can other people understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

5. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

8. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

9. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

10. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No



**Follow-up action taken (check all that apply):**

- Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_
- Share results with primary health care provider.
- Refer for hearing screening.
- Refer for vision screening.
- Refer for behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time.
- Other (specify): \_\_\_\_\_

**ASQ-3 33-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. When you ask your child to point to his nose, eyes, hair, feet, ears, and so forth, does he correctly point to at least seven body parts? (He can point to parts of himself,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

you, or a doll. Mark "SOMETIMES" if he correctly points to at least three different body parts.)

2. Does your child make sentences that are three or four words long?

3. Without giving your child help by pointing or using gestures, ask her to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?

4. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying"). You may ask, "What is the dog (or boy) doing?"

5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle, and ask your child to move the zipper down. Return the zipper to the middle, and ask your child to move the zipper up. Do this several times, placing the zipper in the middle before

asking your child to move it up or down.

Does your child consistently move the zipper up when you say "up" and down when you say "down"?

6. When you ask, "What is your name?" does your child say his first name or nickname?

**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. Does your child run fairly well, stopping herself without bumping into things or falling?

2. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?

3. Does your child jump with both feet leaving the floor at the same time?

4. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)

5. Does your child stand on one foot for about 1 second without holding onto anything?  
(W1\_pr\_as33g\_5)




6. While standing, does your child throw a ball overhand by raising his arm to shoulder height and throwing the ball forward? (Dropping the ball or throwing the ball underhand should be scored as "NOT YET.")




**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?




2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?




3. After your child watches you draw a line from one side of the paper to the other side, ask him to make a line like yours. Do not let your child trace your line. Does your



up four objects in a row? (You can also use spools of thread, small boxes, or other toys.)

3. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?

  

4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "YES" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")

  

5. When you say, "Say 'seven three,'" does your child repeat just the two numbers in the same order?

Do not repeat the numbers. If necessary, try another pair of numbers and say, "Say 'eight two.'" (Your child must repeat just one series of two numbers for you to answer "YES" to this question.)

  

6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? (You may say, "Tell

me about your picture," or ask, "What is this?" to prompt her.)

**PERSONAL-SOCIAL**

	YES	SOMETIMES	NOT YET
1. Does your child use a spoon to feed herself with little spilling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your child put on a coat, jacket, or shirt by herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. After you put on loose-fitting pants around his feet, does your child pull them completely up to his waist?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**OVERALL**

1. Do you think your child hears well? If no, explain.



Yes

No \_\_\_\_\_

2. Do you think your child talks like other toddlers her age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Can other people understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

5. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain.

Yes

No \_\_\_\_\_

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

8. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

9. Do you have any concerns about your child's behavior? If yes, explain.

Yes \_\_\_\_\_

No

10. Does anything about your child worry you? If yes, explain.

Yes \_\_\_\_\_

No

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_

**ASQ-3 36-Month Version**

Please provide the following information.

Date ASQ completed (MM/DD/YYYY):

\_\_\_\_\_

Child's date of birth (MM/DD/YYYY):

\_\_\_\_\_

Child's sex

Male

Female

Does the child have a diagnosed disability or special need (e.g., autism, speech delay)?

If yes, please specify.

Yes \_\_\_\_\_

No

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please click in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.

**COMMUNICATION**

	YES	SOMETIMES	NOT YET
1. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least seven body parts? (She can point to parts of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

herself, you, or a doll.  
Mark "sometimes" if she correctly points to at least three different body parts.)

2. Does your child make sentences that are three or four words long?

3. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?

4. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"

5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle and ask your child to move the zipper down. Return the zipper to the middle and ask your child to move the zipper up. Do this several times, placing the zipper in the middle before asking your child to move it

up or down. Does your child consistently move the zipper up when you say "up" and down when you say "down"?

6. When you ask, "What is your name?" does your child say both her first and last names?




**GROSS MOTOR**

YES

SOMETIMES

NOT YET

1. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?




2. Does your child jump with both feet leaving the floor at the same time?




3. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)




4. Does your child stand on one foot for about 1 second without holding onto anything?




5. While standing, does your child throw a ball overhand by raising his arm to

shoulder height and throwing the ball forward? (Dropping the ball or throwing the ball underhand should be scored as "NOT YET.")

6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?

**FINE MOTOR**

YES

SOMETIMES

NOT YET

1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?

2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

3. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?

4. After your child watches you draw a line from one side of

the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?

5. Does your child try to cut paper with child-safe scissors? He does not need to cut the paper but must get the blades to open and close while holding the paper with the other hand. (You may show your child how to use scissors. Carefully watch your child's use of scissors for safety reasons.)

6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?

                                          

                                          

**PROBLEM SOLVING**

YES                      SOMETIMES                      NOT YET

1. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up four objects in a row? (You can also use spools of thread, small boxes, or other toys.)

                                          

2. If your child wants something he cannot reach, does he find a

chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?

3. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")

4. When you say, "Say 'seven three,'" does your child repeat just the two numbers in the same order? Do not repeat the numbers. If

necessary, try another pair of numbers and say, "Say 'eight two.'" (Your child must repeat just one series of two numbers for you to answer "YES" to this question.)

5. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it?

6. When you say, "Say 'five eight three,'" does your child repeat just the three numbers in the same order? Do not repeat the numbers. If



necessary, try another series of numbers and say, "Say 'six nine two.'" (Your child must repeat just one series of three numbers for you to answer "YES" to this question.)

**PERSONAL-SOCIAL**

	YES	SOMETIMES	NOT YET
1. Does your child use a spoon to feed herself with little spilling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your child push a little wagon, stroller, or toy on wheels, steering it around objects and backing out of corners if he cannot turn?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your child put on a coat, jacket, or shirt by himself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does your child take turns by waiting while another child or adult takes a turn?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**OVERALL**

1. Do you think your child hears well? If no, explain.

Yes

No \_\_\_\_\_

2. Do you think your child talks like other children her age? If no, explain.

Yes

No \_\_\_\_\_

3. Can you understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

4. Can other people understand most of what your child says? If no, explain.

Yes

No \_\_\_\_\_

5. Do you think your child walks, runs, and climbs like other children his age? If no explain.

Yes

No \_\_\_\_\_

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain.

Yes \_\_\_\_\_

No

7. Do you have any concerns about your child's vision? If yes, explain.

Yes \_\_\_\_\_

No

8. Has your child had any medical problems in the last several months? If yes, explain.

Yes \_\_\_\_\_

No

9. Do you have any concerns about your child's behavior? If yes, explain.

Yes (1) \_\_\_\_\_

No (2)

10. Does anything about your child worry you? If yes, explain.

Yes (1) \_\_\_\_\_

No (2)

**Follow-up action taken** (check all that apply):

Provide activities and rescreen in \_\_\_\_\_ months (specify number of months until rescreen): \_\_\_\_\_

Share results with primary health care provider.

Refer for hearing screening.

Refer for vision screening.

Refer for behavioral screening.

Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_

Refer to early intervention/early childhood special education.

No further action taken at this time.

Other (specify): \_\_\_\_\_