ASQ-3 Ages & Stages Questionnaires®

18 Month Questionnaire

17 months 0 days through 18 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

P101180100

18 Month Questionnaire

17 months 0 days through 18 months 30 days

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 fill 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 child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

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 *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?")* Please give an example of your child's word combinations:	○	○	○	___

COMMUNICATION TOTAL ___

E101180200

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?	○	○	○	____
2. Does your child move around by walking, rather than by crawling on her hands and knees?	○	○	○	____
3. Does your child walk well and seldom fall?	○	○	○	____
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)?	○	○	○	____
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.)*	○	○	○	____
6. 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.)* 	○	○	○	____

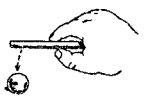
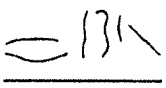
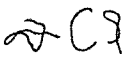
GROSS MOTOR TOTAL ____

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.)* 	○	○	○	____
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.)*	○	○	○	____
3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw? 	○	○	○	____
4. Does your child stack three small blocks or toys on top of each other by himself?	○	○	○	____
5. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	○	○	○	____
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	○	○	○	____

FINE MOTOR TOTAL ____

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.)*	○	○	○	____
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? 	○	○	○	____
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.)*	○	○	○	____
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	○	○	○	____
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.)* Count as "yes"  Count as "not yet" 	○	○	○	____
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.)*	○	○	○	____ *

PROBLEM SOLVING TOTAL ____

**If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

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?	○	○	○	____

PERSONAL-SOCIAL TOTAL ____

OVERALL

Parents and providers may use the space below for additional comments.

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

OVERALL *(continued)*

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

18 Month ASQ-3 Information Summary

17 months 0 days through 18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	●	○	○	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ☐ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or 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): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101180700

Date of Service: _____ Acct #: _____
Patient Name: _____ DOB: _____

Medical Screening Questionnaire

Does your child have a sibling or playmate that has had lead poisoning?	YES	NO	UNSURE
Does your child live in or regularly visit a house or childcare facility built before 1978 that has been renovated in the last 6 months? Do you live in or visit a home or facility built before 1950?	YES	NO	UNSURE
Does your child chew on or eat non-food items like paint chips or dirt?	YES	NO	UNSURE
Was your child born in a country or traveled for longer than a week to a country at high risk for tuberculosis? Is there a family member or close contact with TB or had a positive TB test?	YES	NO	UNSURE
Is your child infected with HIV or have any conditions that lower the immune system?	YES	NO	UNSURE
Has your child been exposed to anyone who is in jail, has HIV, is homeless, or uses illegal drugs?	YES	NO	UNSURE
Has a doctor ever ordered a test for your child's heart or does your child see a Cardiologist?	YES	NO	UNSURE
Has your child ever had discomfort, pain, or pressure in his chest during exercise?	YES	NO	UNSURE
Has your child ever had extreme shortness of breath, or extreme fatigue during exercise (different from other children)?	YES	NO	UNSURE
Has your child fainted or passed out, or had a seizure DURING or AFTER exercise, emotion, or startle?	YES	NO	UNSURE
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (Including SIDS, car accident, drowning, others) or near drowning? If yes, what? _____	YES	NO	UNSURE
Does your child have a parent or sibling with the following conditions? Hypertrophic cardiomyopathy, long or short QT syndrome, Marfans or Loeys-Dietz, Arrhythmogenic right ventricular cardiomyopathy, Brugada syndrome, Catecholaminergic polymorphic ventricular tachycardia	YES	NO	UNSURE
Anyone younger than 50 years old with a pacemaker or implantable defibrillator?	YES	NO	UNSURE
Do you have any concerns about how your child sees?	YES	NO	UNSURE
Do you have any concerns about how your child hears?	YES	NO	UNSURE
Do you have any concerns about your child's speech?	YES	NO	UNSURE
Does anyone in your household smoke?	YES	NO	UNSURE
Do you have city or well water?	CITY		WELL
Does your child have a dentist? If yes, have they been seen in the last 6 months?	YES	NO	

For Patients 11 years and older

Do you wear a seat belt all the time? YES NO
Are you or have you ever been sexually active? YES NO

Do you or have you ever ridden in a car driven by someone who was using drugs or alcohol? YES NO
Do you or have you ever smoked cigarettes (regular or electronic)/VAPE/JUUL? YES NO
Do you or have you ever used any kind of drugs including synthetic marijuana (spice, K2) or alcohol? YES NO
Have you ever gotten into trouble while using drugs or alcohol? YES NO
Do you use anything else to get high (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? YES NO

PLEASE ANSWER THE QUESTIONS ON THE BACK IF YOU ARE 11 YEARS OR OLDER.

Date: _____ **Acct #:** _____

Patient Name(s): _____ **DOB:** _____

PEDIATRIC ASSOCIATES

The services listed below may be provided by Pediatric Associates and may not be covered by your insurance carrier. I understand that **I will be responsible for the services rendered**. This includes but is not limited to Hearing and Vision Screenings, Fluoride Varnish, Ages & Stages, and Vanderbilt forms.

We are unable to verify coverage on all patients: therefore, it is your responsibility to check with your insurance carrier to determine if the services are covered.

IMMUNIZATIONS:

1. _____ I have **NO** insurance to pay for immunizations (includes: Medi-share, Liberty Aliera, Unity, OneShare, Solidarity, Christian Health Ministries, and Samaritan)
2. _____ I have Medicaid/Peachcare/Amerigroup/Peachstate/Caresource
3. _____ My insurance pays for immunizations
4. _____ My insurance does **NOT** cover preventative services
5. _____ I request a copy of an updated 3231 Immunization Form

* You will be provided with an information packet regarding immunizations administered today. *

Please be aware that we are now required to do hearing and vision screens at the ages of 3, 4, 5, 6, 8, 10, 15 and 18yrs. **Your insurance carrier may or may not cover the hearing and/or vision screen. Please be aware that you will be responsible for the $20.00 charge for the hearing screen and $20.00 for the vision screen if it is not a covered service.**

There will be a $10.00 charge for Fluoride Varnish if it is not a covered service. This will be performed at 9mos, 15mos, 24mos, 30mos, and 36mos.

I hereby give consent for immunizations to be administered to my child today and/or have the hearing and/or vision screening and/or Fluoride Varnish completed.

_____ I decline to have the Hearing and/or Vision screen completed at this time.

_____ I decline to have the Fluoride Varnish completed at this time.

Parent/Guardian Signature: _____

Witness: _____