



Ages & Stages Questionnaires®

36 Month Questionnaire

34 months 16 days through 38 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 gender: ☐ Male ☐ Female
Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____
Relationship to child:
☐ Parent ☐ Guardian ☐ Teacher ☐ Child care provider
Street address: _____
☐ 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 #: _____
Program ID #: _____
Program name: _____



36 Month Questionnaire

34 months 16 days
through 38 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:

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 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? Please give an example:







<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

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?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION TOTAL _____

GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. 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"/>	___
2. Does your child jump with both feet leaving the floor at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your child walk up stairs, using only one foot on each stair? <i>(The left foot is on one step, and the right foot is on the next.)</i> She may hold onto the railing or wall. <i>(You can look for this at a store, on a playground, or at home.)</i>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your child stand on one foot for about 1 second without holding onto anything?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. While standing, does your child throw a ball overhand by raising his arm to shoulder height and throwing the ball forward? <i>(Dropping the ball or throwing the ball underhand should be scored as "not yet.")</i>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
GROSS MOTOR TOTAL					___

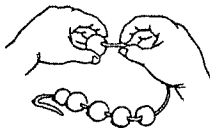
FINE MOTOR

		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?	<div style="text-align: center;"> Count as "yes"  <hr/> Count as "not yet"  </div>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

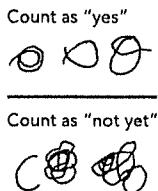
FINE MOTOR (continued)

YES SOMETIMES NOT YET

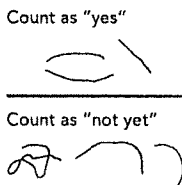
2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

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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?

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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?

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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.)

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

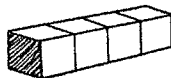
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FINE MOTOR TOTAL

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.)

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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)?

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PROBLEM SOLVING

(continued)

YES

SOMETIMES

NOT YET

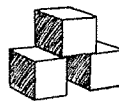
3. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:

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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.)

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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?

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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.)

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PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

YES

SOMETIMES

NOT YET

1. Does your child use a spoon to feed herself with little spilling?
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?
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?
4. Does your child put on a coat, jacket, or shirt by himself?
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?
6. Does your child take turns by waiting while another child or adult takes a turn?

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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 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

OVERALL (continued)

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



36 Month ASQ-3 Information Summary

34 months 16 days through
38 months 30 days

Child's name: _____ Date ASQ completed: _____

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

Administering program/provider: _____

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	30.99		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	36.99		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	18.07		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	30.29		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	35.33		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- | | | | | | |
|---|-----|-----------|---|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Family history of hearing impairment?
Comments: | YES | No |
| 2. Talks like other children his age?
Comments: | Yes | NO | 7. Concerns about vision?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Any medical problems?
Comments: | YES | No |
| 4. Others understand most of what your child says?
Comments: | Yes | NO | 9. Concerns about behavior?
Comments: | YES | No |
| 5. Walks, runs, and climbs like other children?
Comments: | Yes | NO | 10. Other concerns?
Comments: | YES | No |

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						

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 Alera, 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: _____