<table>
<thead>
<tr>
<th>Category</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>Do you have concerns about how your child hears?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Do you have concerns about how your child speaks?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td>Vision</td>
<td>Do you have concerns about how your child sees?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Does your child hold objects close when trying to focus?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Do your child's eyes appear unusual or seem to cross, drift, or be lazy?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Do your child's eyelids droop or does one eyelid tend to close?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Have your child's eyes ever been injured?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td>Lead</td>
<td>Does your child have a sibling or playmate who has or had lead poisoning?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Does your child live in or regularly visit a house or child care facility build before 1950?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Has a family member or contact had tuberculosis or a positive skin test?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Is your child infected with HIV?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Does your child have parents or grandparents who have had a stroke or heart problem before age 55?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Does your child have a parent with elevated blood cholesterol (240 mg/dl or higher) or who is taking cholesterol medication?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
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<tr>
<td>Anemia</td>
<td>Do you ever struggle to put food on the table?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Does your child have a dentist?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
</tr>
<tr>
<td></td>
<td>Does your child's primary water source contain fluoride?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unsure</td>
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</tbody>
</table>
M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc.?  
   Yes  No
2. Does your child take an interest in other children?  
   Yes  No
3. Does your child like climbing on things, such as up stairs?  
   Yes  No
4. Does your child enjoy playing peek-a-boo/hide-and-seek?  
   Yes  No
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?  
   Yes  No
6. Does your child ever use his/her index finger to point, to ask for something?  
   Yes  No
7. Does your child ever use his/her index finger to point, to indicate interest in something?  
   Yes  No
8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?  
   Yes  No
9. Does your child ever bring objects over to you (parent) to show you something?  
   Yes  No
10. Does your child look you in the eye for more than a second or two?  
    Yes  No
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)  
    Yes  No
12. Does your child smile in response to your face or your smile?  
    Yes  No
13. Does your child imitate you? (e.g., you make a face—will your child imitate it?)  
    Yes  No
14. Does your child respond to his/her name when you call?  
    Yes  No
15. If you point at a toy across the room, does your child look at it?  
    Yes  No
16. Does your child walk?  
    Yes  No
17. Does your child look at things you are looking at?  
    Yes  No
18. Does your child make unusual finger movements near his/her face?  
    Yes  No
19. Does your child try to attract your attention to his/her own activity?  
    Yes  No
20. Have you ever wondered if your child is deaf?  
    Yes  No
21. Does your child understand what people say?  
    Yes  No
22. Does your child sometimes stare at nothing or wander with no purpose?  
    Yes  No
23. Does your child look at your face to check your reaction when faced with something unfamiliar?  
    Yes  No

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24 Month Questionnaire

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: ____________________________

Child's gender:

- ☐ Male
- ☐ Female

Person filling out questionnaire

First name: ____________________________  Middle initial: ____________________________  Last name: ____________________________

Relationship to child:

- ☐ Parent
- ☐ Guardian
- ☐ Teacher
- ☐ Child care provider
- ☐ Grandparent or other relative
- ☐ Foster parent
- ☐ Other: ____________________________

Street address: ____________________________

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: ____________________________

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24 Month Questionnaire

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

1. 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?” (She needs to identify only one picture correctly.)

   YES  SOMETIMES  NOT YET

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.)

   YES  SOMETIMES  NOT YET

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.”

   YES  SOMETIMES  NOT YET

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?

   YES  SOMETIMES  NOT YET

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?”) Please give an example of your child’s word combinations:

   YES  SOMETIMES  NOT YET
COMMUNICATION (continued)

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

---

GROSS MOTOR

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?

---

---

*If Gross Motor Item 6 is marked “yes” or “sometimes,” mark Gross Motor Item 2 “yes.”
FINE MOTOR

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

2. Does your child turn the pages of a book by herself? (She may turn more than one page at a time.)
   - YES  
   - SOMETIME  
   - NOT YET  

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?
   - YES  
   - SOMETIME  
   - NOT YET  

4. Does your child flip switches off and on?
   - YES  
   - SOMETIME  
   - NOT YET  

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.)
   - YES  
   - SOMETIME  
   - NOT YET  

6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?
   - YES  
   - SOMETIME  
   - NOT YET  

FINE MOTOR TOTAL

PROBLEM SOLVING

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.)
   - YES  
   - SOMETIME  
   - NOT YET  

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.)
   - YES  
   - SOMETIME  
   - NOT YET  

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?
   - YES  
   - SOMETIME  
   - NOT YET  

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?
   - YES  
   - SOMETIME  
   - NOT YET  

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 to "help" you in the kitchen?)
   - YES  
   - SOMETIME  
   - NOT YET  

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PROBLEM SOLVING (continued)

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

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 a 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

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

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

   O YES  O NO

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

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

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

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

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

7. Has your child had any medical problems in the last several months? If yes, explain:
OVERALL (continued)

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

   

   

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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.

<table>
<thead>
<tr>
<th>Area</th>
<th>Cutoff</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>25.17</td>
<td></td>
</tr>
<tr>
<td>Gross Motor</td>
<td>38.07</td>
<td></td>
</tr>
<tr>
<td>Fine Motor</td>
<td>35.16</td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td>29.78</td>
<td></td>
</tr>
<tr>
<td>Personal-Social</td>
<td>31.54</td>
<td></td>
</tr>
</tbody>
</table>


1. Hears well?
   Comments: ___________________________
   Yes NO

6. Concerns about vision?
   Comments: ___________________________
   YES No

2. Talks like other toddlers his age?
   Comments: ___________________________
   Yes NO

7. Any medical problems?
   Comments: ___________________________
   YES No

3. Understand most of what your child says?
   Comments: ___________________________
   Yes NO

8. Concerns about behavior?
   Comments: ___________________________
   YES No

4. Walks, runs, and climbs like other toddlers?
   Comments: ___________________________
   Yes NO

9. Other concerns?
   Comments: ___________________________
   YES No

5. Family history of hearing impairment?
   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).

<table>
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<th></th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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