ASQ-3 Ages & Stages Questionnaires®

17 months 0 days through 18 months 30 days

18 Month Questionnaire

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

Date ASQ completed: 10092020 (MM DD YYYY)

Child's information

Child's first name: Jazmine

Middle initial: K

Child's last name: ASHLEY

Child's date of birth: 05032019 (MM DD YYYY)

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

Child's gender: ◯ Male ☒ Female

Person filling out questionnaire

First name: Danina

Middle initial: H

Last name: ASHLEY

Street address: 14926 LONAGER Ln

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

City: Haynesville

State/Province: MO

ZIP/Postal code: 65583

Country: USA

Home telephone number: 5735280078

Other telephone number: (crossed out)

E-mail address: Did not want to give out info

Names of people assisting in questionnaire completion: NA

PROGRAM INFORMATION

Child ID #: N.A

Age at administration, in months and days: 17 (MM) 06 (DD)

Program ID #: N.A

If premature, adjusted age, in months and days: XX (MM) XX (DD)

Program name: Lakeview College of Nursing

E101180100

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?	✓	○	○	10
2. Does your child move around by walking, rather than by crawling on her hands and knees?	✓	○	○	10
3. Does your child walk well and seldom fall?	✓	○	○	10
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)?	✓	○	○	10
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.)*	✓	○	○	10
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.)* 	✓	○	○	10
			GROSS MOTOR TOTAL	60

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.)* 	✓	○	○	10
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.)*	✓	○	○	10
3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw? 	✓	○	○	10
4. Does your child stack three small blocks or toys on top of each other by himself?	✓	○	○	10
5. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	✓	○	○	10
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	✓	○	○	10
			FINE MOTOR TOTAL	60

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.)*	✓	○	○	10
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? 	○	○	✗	0
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.)*	✓	○	○	10
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	✓	○	○	10
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" = 1 3 1 Count as "not yet" = 2 C 9	✓	○	○	10
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.)*	✓	○	○	10
			PROBLEM SOLVING TOTAL	50

**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?	○	○	✗	0
2. Does your child play with a doll or stuffed animal by hugging it?	✓	○	○	10
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	✓	○	○	10
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?	✓	○	○	10
5. Does your child drink from a cup or glass, putting it down again with little spilling?	✓	○	○	10
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	✓	○	○	10
			PERSONAL-SOCIAL TOTAL	50

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

N.A

2. Do you think your child talks like other toddlers his age? If no, explain: ⊘ YES ○ NO

N.A

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

N.A

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

N.A.

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ⊘ NO

N.A

6. Do you have concerns about your child's vision? If yes, explain: ○ YES ⊘ NO

N.A.

OVERALL (continued)

7. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ⊗ NO

N.A.

8. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ⊗ NO

N.A.

9. Does anything about your child worry you? If yes, explain: ○ YES ⊗ NO

N.A.

E101180600

ASQ-3 18 Month ASQ-3 Information Summary

17 months 0 days through 18 months 30 days

Child's name: Jazmine Ashley
Child's ID #: N.A
Administering program/provider: Lakeview College of Nursing

Date ASQ completed: 05/09/2020
Date of birth: 06/03/2019
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	UA	●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38	60	●	●	●	●	●	●	●	●	○	○	○	○	●
Fine Motor	34.32	60	●	●	●	●	●	●	●	○	○	○	○	○	●
Problem Solving	25.74	50	●	●	●	●	●	●	○	○	○	○	●	○	○
Personal-Social	27.19	50	●	●	●	●	●	●	○	○	○	○	●	○	○

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.
X 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	X	X	X	X	X	X
Gross Motor	Y	Y	Y	Y	Y	Y
Fine Motor	Y	Y	Y	Y	Y	X
Problem Solving	X	N	Y	Y	Y	Y
Personal-Social	U	Y	Y	Y	Y	Y

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