



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:

M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth:

M M D D Y Y Y Y

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: M M D D

Program ID #:

If premature, adjusted age, in months and days: M M D D

Program name:



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Names of people assisting in questionnaire completion:

PROGRAM INFORMATION	
Child ID #: <input type="text"/>	Age at administration, in months and days: <input type="text"/> <input type="text"/> M M D D
Program ID #: <input type="text"/>	If premature, adjusted age, in months and days: <input type="text"/> <input type="text"/> M M D D
Program name: <input type="text"/>	

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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
2. Does your child move around by walking, rather than by crawling on her hands and knees?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
3. Does your child walk well and seldom fall?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
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 checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
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.)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
				GROSS MOTOR TOTAL
				<u>40</u>



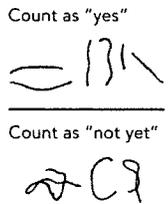
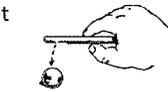
FINE MOTOR

	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 checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
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 checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
4. Does your child stack three small blocks or toys on top of each other by himself?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<u>0</u>
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 checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
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 checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
				FINE MOTOR TOTAL
				<u>30</u>



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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
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 checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
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 checked="" type="radio"/>	<u>0</u>
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.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<u>0</u> *
				PROBLEM SOLVING TOTAL <u>35</u>



*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?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
2. Does your child play with a doll or stuffed animal by hugging it?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
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?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<u>10</u>
5. Does your child drink from a cup or glass, putting it down again with little spilling?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<u>5</u>
				PERSONAL-SOCIAL TOTAL <u>40</u>

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?
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 6 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						