

Ages & Stages Questionnaires@

24 Month Questionnaire

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

Date ASQ completed: 2/1/23

Child's information

Middle: Quanton

Child's first name: Terron

initial: Child's last name: Littles

Child's date of birth:
11/6/20

Child's gender:
male

Person filling out questionnaire

First name: Tirae Last name: Littles

Middle
initial: A

Street address: 921 MACOMBER DR urbana IL

Relationship to child: nephew

Names of people assisting in questionnaire completion: Terrell littles

PROGRAM INFORMATION

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child 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.

	YES	SOMETIMES	NOT YET
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.)	0	0	0
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 he or her words are difficult to understand.)	0	0	0
3. Without your giving him clues by pointing or using gestures, can your child carry out at least three of these kinds of directions? <input type="radio"/> a. "Put the toy on the table." <input type="radio"/> d. "Find your coat." <input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand." <input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book."	0	0	0
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?	0	0	0
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 "byebye," "all gone," "all right," and "What's that?")	0	0	0

Please give an example of your child's word combinations:

COMMUNICATION

YES NOT YET

0 0

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onti

Month

COMMUNICATION

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

0

COMMUNICATION TOTAL

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.)

YES SOMETIMES NOT YET

0 0 0

SOMETIMES

2. When you show your child how to kick a large ball, does he or she 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 YES)

3. Does your child walk either up or down at least two railing or wall. My nephew is able to walk up and down



steps 0 0 by herself? She may hold onto the stairs holding the railing.

4. Does your child run fairly well, stopping herself nephew is able to run freely without falling or bumping



without 0 0 0 bumping into things or falling? Yes my into things.

5. Does your child jump with both feet leaving the floor at jump with both feet at the same time.



the 0 0 0 same time? Yes my nephew is able to



6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?

Yes, sometimes

GROSS MOTOR TOTAL

*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."

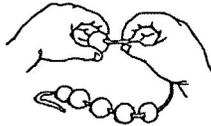


FINE MOTORSOMETIMES

		0	
2. Does your child turn the pages of a book by herself? (She may turn more than one page at a time.)	0		0
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?	0		0
4. Does your child flip switches off and on?	0		
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.)	0		0
		0	
		0	
		0	
		0	
		0	

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

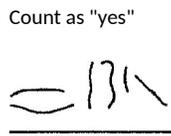
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0

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET
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.)	0	0	0
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-	0	0	0



- pop bottle or baby bottle.)
- | | | | |
|--|----------|---|---|
| 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? | 0 | 0 | 0 |
| 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? | 0 | 0 | 0 |
| 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 | 0 | 0 | 0 |
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? FINE MOTOR TOTAL
- YES**
- "help" you in the kitchen)?

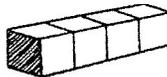
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(ASQ-3™)

IAASQ-β

PROBLEM SOLVING (cont,nued)

6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and tie up four objects in a row? (You can also use spools of thread, small boxes, or other toys.)



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

PERSONAL-SOCIAL

1. Does your child drink from a cup or glass, putting it down again with little spilling?

YES NOT YET 0 0

it around objects and backing out of corners if he cannot turn?

PROBLEM SOLVING TOTAL

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."

YES SOMETIMES NOT YET

0 0

0 0

OVERALL

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

0 0 0

0 0 0

1, Do you think your child hears well? If no, explain: Yes my nephew hears very well.

SOMETIMES

0 0 0

0 0 0

0

PERSONAL-SOCIAL TOTAL

Empty rounded rectangular box for comments.

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

Empty rounded rectangular box for comments.

OVERALL

on

3. Can you understand most of what your child says? If no, explain: Yes im always able to understand what my nephew says when he speaks.

Empty rounded rectangular box for comments.

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

[Empty response box]

Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: **NO**

YES

[Empty response box]

Do you have any concerns about your child's vision? If yes, explain: **NO**

[Empty response box]

Has your child had any medical problems in the last several months? If yes, explain: **NO**

[Empty response box]

4.

5.

6.

7.



OVERALL (continued)

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

9- Does anything about your child worry you? If yes, explain: **NO** YES

24 Month ASQ-3 Information Summary 23 months 0 days through 25 months 15 days

Child's name:
 Child's ID
 Administering program/provider:

Date ASQ completed:
 Date of birth:

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	25.17	10										<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	38.07	10							<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	35.16	10							<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	29.78	5									<input checked="" type="radio"/>				
Personal-Social	31.54	10									<input checked="" 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. 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. _____ 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.
 If the child's total score is in the _____

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

Provide activities and rescreen in _____ months.

Share results with primary health care provider.

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).	Communication	Gross Motor	Fine Motor	Problem Solving	Personal-Social
Communication					
Gross Motor					
Fine Motor					
Problem Solving					
Personal-Social					

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):