



# Ages & Stages Questionnaires®

## 20 Month Questionnaire

19 months 0 days through 20 months 30 days



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

Date ASQ completed: **06092023**  
M M D D Y Y Y Y

### Child's information

Child's first name: **A u t u m n** Middle initial: **J** Child's last name: **m i l l e r**

Child's date of birth: **10092021** M M D D Y Y Y Y  
If child was born 3 or more weeks prematurely, # of weeks premature: **40**  
Child's gender:  Male  Female

↳ adjustment is not needed

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_  
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: \_\_\_\_\_

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

### PROGRAM INFORMATION

Child ID #: \_\_\_\_\_ Age at administration, in months and days: **20** M **00** D  
Program ID #: \_\_\_\_\_ If premature, adjusted age, in months and days: \_\_\_\_\_ M \_\_\_\_\_ D  
Program name: \_\_\_\_\_

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:

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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

	YES	SOMETIMES	NOT YET	
1. 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.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
2. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
3. 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?" (He needs to identify only one picture correctly.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
5. Without your giving him clues by pointing or using gestures, can your child carry out at least three of these kinds of directions?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
<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."				
6. 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:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10

"one more" → talking about a ~~engage~~ Crayon.

COMMUNICATION TOTAL **60**

## GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	10
2. Does your child walk well and seldom fall?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
3. 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
4. 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
				
5. Does your child run fairly well, stopping herself without bumping into things or falling?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
				
6. Does your child walk either up or down at least two steps by himself? He may also hold onto the railing or wall.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
				
<b>GROSS MOTOR TOTAL</b>				<b>60</b>

## FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. 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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
				
2. Does your child stack three 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.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
3. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
4. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
5. Does your child stack six small blocks or toys on top of each other by himself?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10

**FINE MOTOR** (continued)

6. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

YES	SOMETIMES	NOT YET
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

5

**FINE MOTOR TOTAL**

55

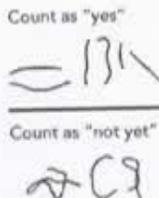
**PROBLEM SOLVING**

1. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

2. 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	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

3. If you do any of the following gestures, does your child copy at least one of them?

- a. Open and close your mouth.
- b. Blink your eyes.
- c. Pull on your earlobe.
- d. Pat your cheek.

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

4. If you give your child a bottle, spoon, or pencil upside down, does she turn it right side up so that she can use it properly?

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

5. 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 at least two blocks side by side? (You can also use spools of thread, small boxes, or other toys.)



YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

6. 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)?

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

**PROBLEM SOLVING TOTAL**

60

**PERSONAL-SOCIAL**

1. Does your child feed herself with a spoon, even though she may spill some food?

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

2. Does your child get your attention or try to show you something by pulling on your hand or clothes?

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

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

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

4. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

YES	SOMETIMES	NOT YET
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

10

**PERSONAL-SOCIAL** (continued)

- |   | YES                              | SOMETIMES             | NOT YET               |    |
|---|----------------------------------|-----------------------|-----------------------|----|
| 5. 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? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
| 6. Does your child eat with a fork?   | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
| PERSONAL-SOCIAL TOTAL   |                                  |                       |                       | 60 |

**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 her age? If no, explain:

YES  NO

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

YES  NO

"Yes & she's getting better each week"

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

YES  NO

**OVERALL** (continued)

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

 YES NO

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

 YES NO

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



# 20 Month ASQ-3 Information Summary

19 months 0 days through  
20 months 30 days

Child's name: Autumn J Miller

Date ASQ completed: 06/09/2023

Child's ID #: NO

Date of birth: 10/09/2021

Administering program/provider: NO

Was age adjusted for prematurity when selecting questionnaire?  Yes  No → not needed

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	20.50	<b>60</b>	●	●	●	●	●	●	●	●	●	●	●	●	●
Gross Motor	39.89	<b>60</b>	●	●	●	●	●	●	●	●	●	●	●	●	●
Fine Motor	36.05	<b>55</b>	●	●	●	●	●	●	●	●	●	●	●	●	●
Problem Solving	28.84	<b>60</b>	●	●	●	●	●	●	●	●	●	●	●	●	●
Personal-Social	33.36	<b>60</b>	●	●	●	●	●	●	●	●	●	●	●	●	●

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

- |  |   |  |   |
|--|---|--|---|
| 1. Hears well?<br>Comments:                                  | <input checked="" type="radio"/> YES <input type="radio"/> NO | 6. Concerns about vision?<br>Comments:   | YES <input type="radio"/> NO <input checked="" type="radio"/> |
| 2. Talks like other toddlers his age?<br>Comments:           | <input checked="" type="radio"/> YES <input type="radio"/> NO | 7. Any medical problems?<br>Comments:    | YES <input type="radio"/> NO <input checked="" type="radio"/> |
| 3. Understand most of what your child says?<br>Comments:     | <input checked="" type="radio"/> YES <input type="radio"/> NO | 8. Concerns about behavior?<br>Comments: | YES <input type="radio"/> NO <input checked="" type="radio"/> |
| 4. Walks, runs, and climbs like other toddlers?<br>Comments: | <input checked="" type="radio"/> YES <input type="radio"/> NO | 9. Other concerns?<br>Comments:          | YES <input type="radio"/> NO <input checked="" type="radio"/> |
| 5. Family history of hearing impairment?<br>Comments:        | YES <input checked="" type="radio"/> NO <input type="radio"/> |  |   |

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						