



12 Month Questionnaire

11 months 0 days
through 12 months 30 days

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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	5
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "yes" if she knows one object.)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
6. When your baby wants something, does he tell you by pointing to it?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
COMMUNICATION TOTAL				55

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
3. Does your baby walk beside furniture while holding on with only one hand?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	10



GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------|-----------------------|----|
| 4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "yes" for this item.) | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
|  | | | | |
| 5. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "yes" for this item.) | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
|  | | | | |
| 6. Does your baby stand up in the middle of the floor by himself and take several steps forward? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |

GROSS MOTOR TOTAL 60

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------|-----------------------|----|
| 1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? (The string may be attached to a toy.) | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | 5 |
|  | | | | |
| 2. Does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? She may rest her arm or hand on the table while doing it. | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
|  | | | | |
| 3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
|  | | | | |
| 4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
|  | | | | |
| 5. Does your baby throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.) | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | 10 |
|  | | | | |
| 6. Does your baby help turn the pages of a book? (You may lift a page for him to grasp.) | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | 5 |

FINE MOTOR TOTAL 50

*If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|--------------------------|----|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? (If she already lets go of the toy into a bowl or box, mark "yes" for this item.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? (You may show him how to do it.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? (If she already scribbles on her own, mark "yes" for this item.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 5 |



PROBLEM SOLVING TOTAL

*If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."

55

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------|--------------------------|----|
| 1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? (If he already lets go of the toy into your hand, mark "yes" for this item.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |
| 6. Does your baby play with a doll or stuffed animal by hugging it? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 |

PERSONAL-SOCIAL TOTAL

60

OVERALL

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

1. Does your baby use both hands and both legs equally well? If no, explain:

YES NO

[Empty rounded rectangular box for explanation]

2. Does your baby play with sounds or seem to make words? If no, explain:

YES NO

[Empty rounded rectangular box for explanation]

3. When your baby is standing, are her feet flat on the surface most of the time? If no, explain:

YES NO

[Empty rounded rectangular box for explanation]

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain:

YES NO

[Empty rounded rectangular box for explanation]

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

YES NO

[Empty rounded rectangular box for explanation]

OVERALL (continued)

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

YES

NO

[Empty rounded rectangular box for explanation]

7. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]

8. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]

9. Does anything about your baby worry you? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]



12 Month ASQ-3 Information Summary

11 months 0 days through
12 months 30 days

Baby's name: Brody Beesley

Date ASQ completed: 04/24/24

Baby's ID #: _____

Date of birth: 04/23/24

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	15.64		●	●	●	●	●	●	●	●	●	●	●	●	●
Gross Motor	21.49		●	●	●	●	●	●	●	●	●	●	●	●	●
Fine Motor	34.50		●	●	●	●	●	●	●	●	●	●	●	●	●
Problem Solving	27.32		●	●	●	●	●	●	●	●	●	●	●	●	●
Personal-Social	21.73		●	●	●	●	●	●	●	●	●	●	●	●	●

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

- | | | | |
|----------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------|
| 1. Uses both hands and both legs equally well?
Comments: | <input checked="" type="radio"/> YES <input type="radio"/> NO | 6. Concerns about vision?
Comments: | YES <input type="radio"/> No <input checked="" type="radio"/> |
| 2. Plays with sounds or seems to make words?
Comments: | <input checked="" type="radio"/> YES <input type="radio"/> NO | 7. Any medical problems?
Comments: | YES <input type="radio"/> No <input checked="" type="radio"/> |
| 3. Feet are flat on the surface most of the time?
Comments: | <input checked="" type="radio"/> YES <input type="radio"/> NO | 8. Concerns about behavior?
Comments: | YES <input type="radio"/> No <input checked="" type="radio"/> |
| 4. Concerns about not making sounds?
Comments: | <input checked="" type="radio"/> YES <input type="radio"/> NO | 9. Other concerns?
Comments: | YES <input type="radio"/> No <input checked="" type="radio"/> |
| 5. Family history of hearing impairment?
Comments: | YES <input type="radio"/> No <input checked="" 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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
If the baby'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						

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