

**ASQ-3** Ages & Stages Questionnaires®

3 months 0 days through 4 months 30 days  
**4 Month Questionnaire**



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

Date ASQ completed: 10/10/24

**Baby's information**

Baby's first name: John Middle initial: M Baby's last name: Edwards  
Baby's date of birth: 06/03/24  
If baby was born 3 or more weeks prematurely, # of weeks premature: \_\_\_\_\_  
Baby's gender:  Male  Female

**Person filling out questionnaire**

First name: Cody Middle initial: A Last name: Edwards  
Street address: 109 E 13th St.  
City: Georgetown State/Province: IL ZIP/Postal code: 61846  
Country: USA Home telephone number: \_\_\_\_\_ Other telephone number: 2177993485  
Relationship to baby:  Parent  Guardian  Teacher  Child care provider  
 Grandparent or other relative  Foster parent  Other: \_\_\_\_\_  
E-mail address: eking@lakeviewcol.edu  
Names of people assisting in questionnaire completion: Erica King

**Program Information**

Baby ID #:	Age at administration in months and days:
Program ID #:	If premature, adjusted age in months and days:
Program name:	



# 4 Month Questionnaire

3 months 0 days through 4 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.

### Notes:

### 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## COMMUNICATION

1. Does your baby chuckle softly?
2. After you have been out of sight, does your baby smile or get excited when he sees you?
3. Does your baby stop crying when she hears a voice other than yours?
4. Does your baby make high-pitched squeals?
5. Does your baby laugh?
6. Does your baby make sounds when looking at toys or people?

	YES	SOMETIMES	NOT YET	
1.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
2.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
3.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	—
4.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
5.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
6.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—

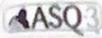
COMMUNICATION TOTAL \_\_\_\_\_

## GROSS MOTOR

1. While your baby is on his back, does he move his head from side to side?
2. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?
3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?
4. When your baby is on her tummy, does she hold her head straight up, looking around? (She can rest on her arms while doing this.)



	YES	SOMETIMES	NOT YET	
1.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
2.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
3.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
4.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—



### GROSS MOTOR

(continued)

5. When you hold him in a sitting position, does your baby hold his head steady?

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

6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers?



<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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GROSS MOTOR TOTAL —

### FINE MOTOR

1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)?



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

2. When you put a toy in her hand, does your baby wave it about, at least briefly?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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3. Does your baby grab or scratch at his clothes?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
-------------------------------------	--------------------------	--------------------------	---

6. When you hold your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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FINE MOTOR TOTAL —

### PROBLEM SOLVING

1. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?

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

2. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes?

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	—
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3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
-------------------------------------	--------------------------	--------------------------	---

4. When you put a toy in her hand, does your baby look at it?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
-------------------------------------	--------------------------	--------------------------	---

5. When you put a toy in his hand, does your baby put the toy in his mouth?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
-------------------------------------	--------------------------	--------------------------	---



**PROBLEM SOLVING** (continued)

6. When you dangle a toy above your baby while she is lying on her back, does your baby wave her arms toward the toy?



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

PROBLEM SOLVING TOTAL \_\_\_

**PERSONAL-SOCIAL**

1. Does your baby watch his hands?



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

2. When your baby has her hands together, does she play with her fingers?
3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?
5. Before you smile or talk to your baby, does he smile when he sees you nearby?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___

6. When in front of a large mirror, does your baby smile or coo at herself?



<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
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PERSONAL-SOCIAL TOTAL \_\_\_

**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

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:

YES     NO



**OVERALL** (continued)

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

YES  NO

[Empty rounded rectangular box for explanation]

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

YES  NO

[Empty rounded rectangular box for explanation]

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

YES  NO

[Empty rounded rectangular box for explanation]

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

YES  NO

[Empty rounded rectangular box for explanation]

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

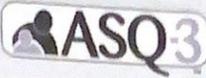
YES  NO

[Empty rounded rectangular box for explanation]

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

YES  NO

[Empty rounded rectangular box for explanation]



# 4 Month ASQ-3 Information Summary

3 months 0 days through  
4 months 30 days

Baby's name: John Edwards Date ASQ completed: 10/10/24  
 Baby's ID #: \_\_\_\_\_ Date of birth: 06/03/24  
 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	34.60		●	●	●	●	●	●	●	●	●	○	○	○	○
Gross Motor	38.41		●	●	●	●	●	●	●	●	●	●	○	○	○
Fine Motor	29.62		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	34.98		●	●	●	●	●	●	●	●	○	○	○	○	○
Personal-Social	33.16		●	●	●	●	●	●	●	●	○	○	○	○	○

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?<br>Comments:    | <b>Yes</b> NO | 5. Concerns about vision?<br>Comments:   | YES <b>No</b> |
| 2. Feet are flat on the surface most of the time?<br>Comments: | <b>Yes</b> NO | 6. Any medical problems?<br>Comments:    | YES <b>No</b> |
| 3. Concerns about not making sounds?<br>Comments:              | YES <b>No</b> | 7. Concerns about behavior?<br>Comments: | YES <b>No</b> |
| 4. Family history of hearing impairment?<br>Comments:          | YES <b>No</b> | 8. Other concerns?<br>Comments:          | YES <b>No</b> |

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.

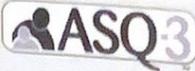
If the baby's total score is in the    area, it is above the cutoff, and the baby's development appears to be on schedule.  
 If the baby's total score is in the    area, it is close to the cutoff. Provide learning activities and monitor.  
 If the baby's total score is in the    area, it is below the 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						



# Ages & Stages Questionnaires®

## 24 Month Questionnaire

23 months 0 days through 25 months 15 days

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



Date ASQ completed: 10/10/24

### Child's information

Child's first name: Brylin Middle initial: A Child's last name: Edwards  
 Child's date of birth: 08/16/22 Child's gender:  Male  Female

### Person filling out questionnaire

First name: Cady Middle initial: A Last name: Edwards  
 Street address: 109 E 13th St Relationship to child:  Parent  Guardian  Teacher  Child care provider  
 Grandparent or other relative  Foster parent  Other:  
 City: Georgetown State/Province: IL ZIP/Postal code: 61846  
 Country: USA Home telephone number: Other telephone number: 2177998485  
 E-mail address: eking@lakeviewcol.edu

Names of people assisting in questionnaire completion: Erica King

### Program Information

Child ID #: \_\_\_\_\_  
 Program ID #: \_\_\_\_\_  
 Program name: \_\_\_\_\_

P101240100



# 24 Month Questionnaire

23 months 0 days through 25 months 15 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 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.

## COMMUNICATION

- |   | 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.)  | <input type="radio"/>            | <input checked="" type="radio"/> | <input type="radio"/> | — |
| 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 her words are difficult to understand.)   | <input checked="" type="radio"/> | <input type="radio"/>            | <input type="radio"/> | — |
| 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 checked="" type="radio"/> | <input type="radio"/>            | <input type="radio"/> | — |
| <input checked="" type="checkbox"/> a. "Put the toy on the table." <input type="checkbox"/> d. "Find your coat."  |                                  |                                  |                       |   |
| <input checked="" type="checkbox"/> b. "Close the door." <input checked="" type="checkbox"/> e. "Take my hand."   |                                  |                                  |                       |   |
| <input type="checkbox"/> c. "Bring me a towel." <input type="checkbox"/> f. "Get your book."  |                                  |                                  |                       |   |
| 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="radio"/> | <input type="radio"/>            | <input type="radio"/> | — |
| 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 "bye-bye," "all gone," "all right," and "What's that?") Please give an example of your child's word combinations: | <input checked="" type="radio"/> | <input type="radio"/>            | <input type="radio"/> | — |

\_\_\_\_\_

**COMMUNICATION**

(continued)

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

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

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	—
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—

2. 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.)



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

3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.



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

4. Does your child run fairly well, stopping herself without bumping into things or falling?



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

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



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

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



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

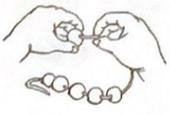
GROSS MOTOR TOTAL —

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



**FINE MOTOR**

1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?
2. Does your child turn the pages of a book by herself? (She may turn more than one page at a time.)
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?
4. Does your child flip switches off and on?
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.)
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

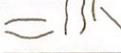


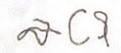
YES	SOMETIMES	NOT YET	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	—
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
<input checked=""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

FINE MOTOR TOTAL —

**PROBLEM SOLVING**

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.)
 

Count as "yes" 

Count as "not yet" 
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-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?
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?
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 "help" you in the kitchen)?

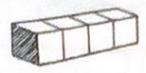
YES	SOMETIMES	NOT YET	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	—
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
<input checked=""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



### PROBLEM SOLVING

(continued)

6. 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 four objects in a row? (You can also use spools of thread, small boxes, or other toys.)



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

PROBLEM SOLVING TOTAL

### PERSONAL-SOCIAL

- Does your child drink from a cup or glass, putting it down again with little spilling?
- Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?
- Does your child eat with a fork?
- 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?
- Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?
- 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	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL-SOCIAL TOTAL

### 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



**OVERALL** (continued)

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

YES  NO

[Empty rounded rectangular box for explanation]

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

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

YES  NO

[Empty rounded rectangular box for explanation]

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

YES  NO

[Empty rounded rectangular box for explanation]

ASQ-3

OVERALL (continued)

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

YES  NO

[Empty rounded rectangular box for explanation]

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

YES  NO

[Empty rounded rectangular box for explanation]

- ...
- ...
- ...
- ...
- ...



# 24 Month ASQ-3 Information Summary

23 months 0 days through  
25 months 15 days

Child's name: Brylin Edwards Date ASQ completed: 10/10/24  
 Child's ID #: \_\_\_\_\_ Date of birth: 08/16/22  
 Administering program/provider: \_\_\_\_\_

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.

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Communication	25.17		●	●	●	●	●	●	●	●	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

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

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

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						

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