



48 Month Questionnaire

45 months 0 days
through 50 months 30 days

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:

COMMUNICATION

1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?

YES

SOMETIMES

NOT YET

2. Does your child answer the following questions? (Mark "sometimes" if your child answers only one question.)

YES

SOMETIMES

NOT YET

"What do you do when you are hungry?" (Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.") Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.") Please write your child's response:

3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?

YES

SOMETIMES

NOT YET

4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?

YES

SOMETIMES

NOT YET

COMMUNICATION (continued)

- | | YES | SOMETIMES | NOT YET | |
|--|----------------------------------|-----------------------|-----------------------|---|
| 5. Without your giving help by pointing or repeating, does your child follow three directions that are <i>unrelated</i> to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up." | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I am going to the park," or "Is there a toy to play with?" or "Are you coming, too?" | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| COMMUNICATION TOTAL | | | | — |

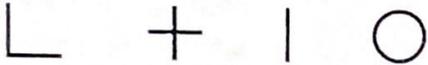
GROSS MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|----------------------------------|----------------------------------|-----------------------|---|
| 1. Does your child catch a large ball with both hands? (You should stand about 5 feet away and give your child two or three tries before you mark the answer.)  | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | — |
| 2. Does your child climb the rungs of a ladder of a playground slide and slide down without help? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. While standing, does your child throw a ball <i>overhand</i> in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. (Dropping the ball or throwing the ball underhand should be scored as "not yet.")  | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling? | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | — |
| 5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? (You may give your child two or three tries before you mark the answer.)  | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| GROSS MOTOR TOTAL | | | | — |

FINE MOTOR

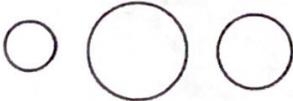
- | | YES | SOMETIMES | NOT YET | |
|--|----------------------------------|-----------------------|-----------------------|---|
| 1. Does your child put together a five- to seven-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?) | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

FINE MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-------------------------------------|-------------------------------------|--------------------------|---|
| 2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? (Your child's drawings should look similar to the design of the shapes below, but they may be different in size.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 
 | | | | |
| 4. Does your child unbutton one or more buttons? (Your child may use his own clothing or a doll's clothing.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | — |
| 6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? (Your child should not go more than 1/4 inch outside the lines on most of the picture.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |

FINE MOTOR TOTAL —

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-------------------------------------|--------------------------|--------------------------|---|
| 1. When you say, "Say 'five eight three,'" does your child repeat just the three numbers in the same order? Do not repeat the numbers. If necessary, try another series of numbers and say, "Say 'six nine two.'" (Your child must repeat just one series of three numbers to answer "yes" to this question.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? (Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
|  | | | | |
| 3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "under the couch." Then ask her to put the ball "between the chairs" and the book "in the middle of the table." | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? (Mark "yes" only if your child answers the question correctly using five colors.) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |

PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|----------------------------------|-----------------------|-----------------------|---|
| 5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure. | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? (Ask this question without providing help by pointing, gesturing, or naming.) | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| PROBLEM SOLVING TOTAL | | | | — |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|----------------------------------|-----------------------|-----------------------|---|
| 1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child tell you at least four of the following? Please mark the items your child knows. | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| <input checked="" type="radio"/> a. First name <input checked="" type="radio"/> d. Last name
<input checked="" type="radio"/> b. Age <input checked="" type="radio"/> e. Boy or girl
<input checked="" type="radio"/> c. City she lives in <input checked="" type="radio"/> f. Telephone number | | | | |
| 3. Does your child wash his hands using soap and water and dry off with a towel without help? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child tell you the names of two or more playmates, not including brothers and sisters? (Ask this question without providing help by suggesting names of playmates or friends.) | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? (You may still need to check and rebrush your child's teeth.) | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)? | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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

OVERALL (continued)

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

YES

NO

[Empty rounded rectangular box for explanation]

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

YES

NO

[Empty rounded rectangular box for explanation]

4. Can other people understand most of what your child says? If no, explain:

YES

NO

[Empty rounded rectangular box for explanation]

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

YES

NO

[Empty rounded rectangular box for explanation]

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

YES

NO

[Empty rounded rectangular box for explanation]

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

YES

NO

[Empty rounded rectangular box for explanation]

OVERALL (continued)

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

YES

NO

[Empty rounded rectangular box for explanation]

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

YES

NO

[Empty rounded rectangular box for explanation]

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

YES

NO

[Empty rounded rectangular box for explanation]



48 Month ASQ-3 Information Summary

45 months 0 days through
50 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

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.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	30.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○

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. Family history of hearing impairment?
Comments: | YES No |
| 2. Talks like other children his age?
Comments: | Yes NO | 7. Concerns about vision?
Comments: | YES No |
| 3. Understand most of what your child says?
Comments: | Yes NO | 8. Any medical problems?
Comments: | YES No |
| 4. Others understand most of what your child says?
Comments: | Yes NO | 9. Concerns about behavior?
Comments: | YES No |
| 5. Walks, runs, and climbs like other children?
Comments: | Yes NO | 10. Other concerns?
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 _____ 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						