Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By **Diane Bricker** and **Jane Squires**
with assistance from ***Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly,*** *and* ***Jane Farrell***

• 18 Month • Questionnaire

On the following pages are questions about activities children 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 check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Be sure to try each activity with your child before checking a box.
- ☑ Try to make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested, fed, and ready to play.
- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Look forward to filling out another questionnaire in _____ months.

ASQ™

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• 18 Month • Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

_____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ™

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, score "yes" for the item.

	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. When your child wants something, does she tell you by *pointing* to it?	❑	❑	❑	___
2. When you ask him to, does your child go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat" or "Go get your blanket.")	❑	❑	❑	___
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	❑	❑	❑	___
4. 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? (Check "yes" even if her words are difficult to understand.)	❑	❑	❑	___
5. Without showing him first, 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.)	❑	❑	❑	___
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:

_____

COMMUNICATION TOTAL ___

GROSS MOTOR *Be sure to try each activity with your child.*				
1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	❑	❑	❑	___
2. Does your child move around by walking, rather than by crawling on her hands and knees?	❑	❑	❑	___
3. Does your child walk well and seldom fall?	❑	❑	❑	___
4. Does your child climb on an object such as a chair to reach something he wants?	❑	❑	❑	___
5. Does your child walk down stairs if you hold onto one of her hands? (You can look for this at a store, on a playground, or at home.)	❑	❑	❑	___
6. When you show him how to kick a large ball, does your child try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, check "yes" for this item.) 	❑	❑	❑	___

GROSS MOTOR TOTAL ___

	YES	SOMETIMES	NOT YET	

FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, check "not yet" for this item.)

❑ ❑ ❑ ___

2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

❑ ❑ ❑ ___

3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw?

❑ ❑ ❑ ___

4. Does your child stack three small blocks or toys on top of each other by herself? (You can also use spools of thread, small boxes, or toys that are about 1 inch in size.)

❑ ❑ ❑ ___

5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)

❑ ❑ ❑ ___

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

❑ ❑ ❑ ___

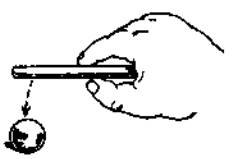
FINE MOTOR TOTAL ___

PROBLEM SOLVING *Be sure to try each activity with your child.*

1. Does your child drop several (six or more) small toys into a container, such as a bowl or box? (You may show him how to do it.)

❑ ❑ ❑ ___

2. After you have shown her how, does your child try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?



❑ ❑ ❑ ___

3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child purposely turn the bottle over to dump it out? You may show him how to do this. You can use a plastic soda-pop bottle or baby bottle.

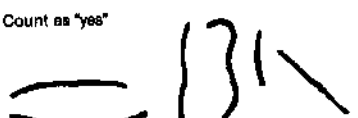
❑ ❑ ❑ ___

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

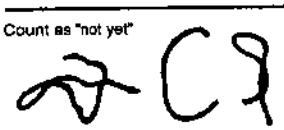
❑ ❑ ❑ ___

5. After he watches 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*? (Scribbling back and forth does not count as "yes.")

Count as "yes"



Count as "not yet"



❑ ❑ ❑ ___

	YES	SOMETIMES	NOT YET	
PROBLEM SOLVING *(continued)*				
6. 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 her how.) (Please allow a few minutes between trying problem solving items 3 and 6.)	❑	❑	❑	___
PROBLEM SOLVING TOTAL				___

"If problem solving item 6 is marked "yes" or "sometimes," mark problem solving item 3 as "yes."

PERSONAL-SOCIAL *Be sure to try each activity with your child.*				
1. While looking at himself in the mirror, does your child offer a toy to his own image?	❑	❑	❑	___
2. Does your child play with a doll or stuffed animal by hugging it?	❑	❑	❑	___
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	❑	❑	❑	___
4. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?	❑	❑	❑	___
5. Does your child drink from a cup or glass, putting it down again with little spilling?	❑	❑	❑	___
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	❑	❑	❑	___
PERSONAL-SOCIAL TOTAL				___

OVERALL *Parents and providers may use the space at the bottom of the next sheet for additional comments.*

1. Do you think your child hears well?	YES ❑	NO ❑
If no, explain: _____		
2. Do you think your child talks like other toddlers his age?	YES ❑	NO ❑
If no, explain: _____		
3. Can you understand most of what your child says?	YES ❑	NO ❑
If no, explain: _____		
4. Do you think your child walks, runs, and climbs like other toddlers her age?	YES ❑	NO ❑
If no, explain: _____		
5. Does either parent have a family history of childhood deafness or hearing impairment?	YES ❑	NO ❑
If yes, explain: _____		

OVERALL *(continued)*

6. Do you have concerns about your child's vision? YES ☐ NO ☐

   If yes, explain: _____

7. Has your child had any medical problems in the last several months? YES ☐ NO ☐

   If yes, explain: _____

8. Does anything about your child worry you? YES ☐ NO ☐

   If yes, explain: _____

18 Month ASQ Information Summary

Child's name: _____ Date of birth: _____

Person filling out the ASQ: _____ Corrected date of birth: _____

Mailing address: _____ Relationship to child: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ completion: _____

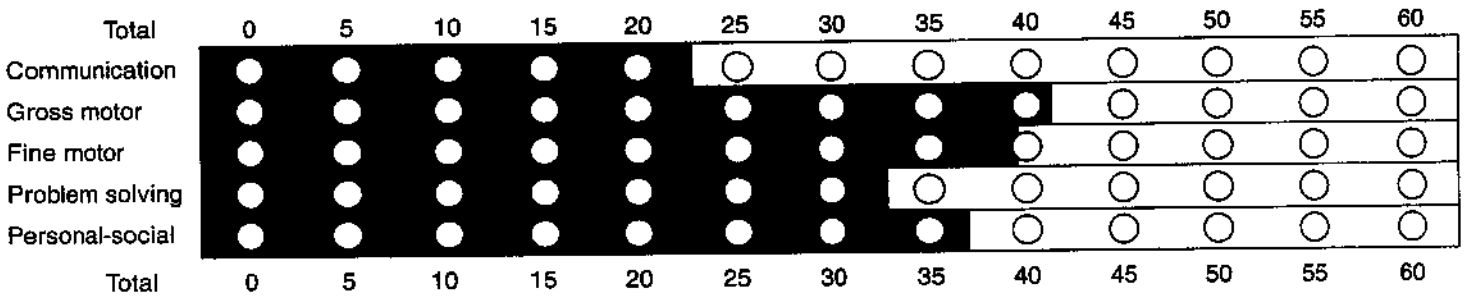
Today's date: _____ _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1.	Hears well? Comments:	YES	NO	5.	Family history of hearing impairment? Comments:	YES	NO
2.	Talks like other toddlers? Comments:	YES	NO	6.	Vision concerns? Comments:	YES	NO
3.	Understand child? Comments:	YES	NO	7.	Recent medical problems? Comments:	YES	NO
4.	Walks, runs, and climbs like others? Comments:	YES	NO	8.	Other concerns? Comments:	YES	NO

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide.*
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



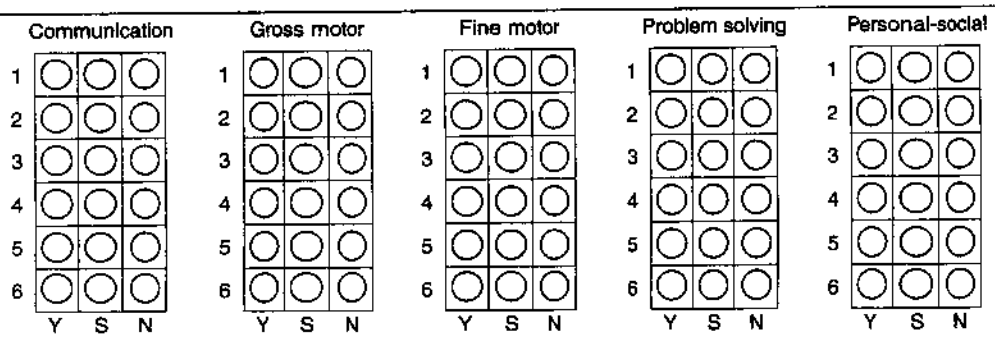
Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the ▭ area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the ■ area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

18 months

	Score	Cutoff
Communication		23.0
Gross motor		41.5
Fine motor		39.5
Problem solving		33.0
Personal-social		37.0



Administering program or provider: _____

Patients Full Name:_____ **Date of Birth:**_____

Tuberculosis Risk Assessment Questionnaire

(Individuals treated for tuberculosis or currently active should not be tested.)Any "yes" answer means the child is at high risk, should receive a tuberculin skin test (Mantoux) which should be read by a health professional and the Public Health Department should be notified (see Section 902.2j)

YES NO

____ ____ 1) Is the child in close contact of a person with infectious tuberculosis?

____ ____ 2) Does the child have HIV infection or is he/she considered at high risk for HIV infection?

____ ____ 3) Is the child foreign born (especially Asian, African, Latin or American), a refugee or a migrant?

____ ____ 4) Is the child in contact with an incarcerated person or a person who was incarcerated or a person who was incarcerated in the past five (5) years?

____ ____ 5) Is the child exposed to the following individuals: HIV infected, institutionalized adolescents or adults, users of illicit drugs?

____ ____ 6) Does the child have a medical condition or treatment of a medical condition which suppresses the immune system?

____ ____ 7) Does the child live in a community in which it has been established that a high risk exists for tuberculosis?

OTHER:_____

M-CHAT

Please fill out the following about how your child usually is. Please try to answer ever question If the behavior is rare (e.g. you've seen it once or twice), please answer as if the child does not do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes No
2.	Does your child take an interest in other children?	Yes No
3.	Does your child like climbing on things, such as up stairs?	Yes No
4.	Does you child enjoy playing peek-a-boo/hide-and-seek?	Yes No
5.	Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes No
6.	Does your child ever use his/her index finger to point to or ask for something?	Yes No
7.	Does your child ever use his/her index finger to point, to indicate an interest in something?	Yes No
8.	Can your child play properly with small toys (e.g., cars or blocks) without just mouthing, fiddling, or dropping them?	Yes No
9.	Does you child ever bring objects over to you (parent) to show you something?	Yes No
10.	Does your child look you in the eye for more than a second or two?	Yes No
11.	Does you child ever sem oversensitive to noise? (e.g., plugging ears)	Yes No
12.	Does your child smile in response to your face or your smile?	Yes No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes No
14.	Does you child respond to his/her name when you call it?	Yes No
15.	If you point at a toy across the room, does your child look at it?	Yes No
16.	Does your child walk?	Yes No
17.	Does your child look at things you are looking at?	Yes No
18.	Does you child make unusual finger movements near his/her face?	Yes No
19.	Does your child try to attract your attention to his/her own activity?	Yes No
20.	Have you ever wondered if your child is deaf?	Yes No
21.	Does your child understand what people say?	Yes No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes No

LEAD RISK ASSESMENT

This questionnaire should be used at the six month maintenance visit to assess the potential for high-dose lead exposure and, therefore, the appropriate frequency of blood lead screening:

Childs Name: Date:

Mothers Name: Address:

City: State: Zip: Phone:

1. Does child live in a house/apartment built before 1960?
   ___Yes
   ___No
   ___Unknown
2. Does child live in a house / apartment built before 1978 that is being remodeled at this time?
   ___ Yes
   ___ No
   ___ Unknown
3. Has anyone living with the child had elevated lead levels?
   __ Yes
   __No
   __Unknown

4. Does anyone living with the child work in a lead industry (radiator shop or ect)?
   __ Yes
   __No
   __Unknown
5. Does child eat paint chips or any non-food item or play in a dirt yard where cars have been parked?
   __No
   __Yes
   __Unknown
6. Does this child live near an active lead smelter, Battery recycling plant?
   __Yes
   __No
   __Unknown

HIGH RISK: If any answer is yes, child is high risk and should be screened for lead toxicity. The children at highest risk are those from 6-36 months who live in dilapidated housing.