



Ages & Stages Questionnaires®

27 Month Questionnaire

25 months 16 days through 28 months 15 days



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

Date ASQ completed: 9/29/17

Child's information

Child's first name: Maria Middle initial: A. Child's last name: Smith

Child's gender:
 Male Female

Child's date of birth: 5/29/15

Person filling out questionnaire

First name: Candace Middle initial: _____ Last name: Smith

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

Street address: Anytown - street

City: Any where State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



27 Month Questionnaire

25 months 16 days
through 28 months 15 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:

Notes:

- 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 _____.

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 giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?

- a. "Put the toy on the table." d. "Find your coat."
- b. "Close the door." e. "Take my hand."
- c. "Bring me a towel." f. "Get your book."

2. 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?

bottle, baby

3. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)

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

5. Does your child make sentences that are three or four words long? Please give an example:

6. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?

COMMUNICATION TOTAL _____

GROSS MOTOR

1. Does your child walk either up or down at least two steps by himself? He may 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

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



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

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



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

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



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

5. Does your child jump forward at least 3 inches with both feet leaving the ground at the same time?



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

6. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or wall.



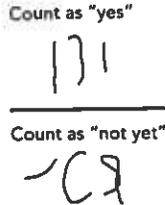
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
-----------------------	----------------------------------	-----------------------	--------------------------

GROSS MOTOR TOTAL

*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."

FINE MOTOR

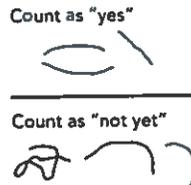
- 1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?
- 2. Does your child flip switches off and on?
- 3. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?



- 4. 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.)
- 5. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?



- 6. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?



YES	SOMETIMES	NOT YET	_____
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	_____
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	_____
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	_____
FINE MOTOR TOTAL			_____

PROBLEM SOLVING

- 1. Does your child pretend objects are something else? For example, does your child hold a cup to his ear, pretending it is a telephone? Does he put a box on her head, pretending it is a hat? Does he use a block or small toy to stir food?
- 2. Does your child put things away where they belong? For example, does she know her toys belong on the toy shelf, her blanket goes on her bed, and dishes go in the kitchen?
- 3. When looking in the mirror, ask "Where is _____?" (Use your child's name.) Does your child point to his image in the mirror?
- 4. 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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	_____
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	_____

PROBLEM SOLVING (continued)

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



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

6. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:



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

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

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

- | | |
|--|--|
| <input checked="" type="radio"/> a. Open and close your mouth. | <input type="radio"/> c. Pull on your earlobe. |
| <input type="radio"/> b. Blink your eyes. | <input type="radio"/> d. Pat your cheek. |

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

2. Does your child eat with a fork?

3. 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?

4. 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?

5. 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."

6. Does your child put on a coat, jacket, or shirt by himself?

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

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

YES

NO

She only says a few words.

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

YES

NO

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

YES

NO

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

YES

NO

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

YES

NO

OVERALL (continued)

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

She is very quiet and doesn't talk much.



27 Month ASQ-3 Information Summary

25 months 16 days through
28 months 15 days

Child's name: Maria Smith Date ASQ completed: 9/29/17
 Child's ID #: _____ Date of birth: 5/29/15
 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	24.02		<input type="radio"/>												
Gross Motor	28.01		<input type="radio"/>												
Fine Motor	18.42		<input type="radio"/>												
Problem Solving	27.62		<input type="radio"/>												
Personal-Social	25.31		<input type="radio"/>												

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