



# Ages & Stages Questionnaires®

## 18 Month Questionnaire

17 months 0 days through 18 months 30 days



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

Date ASQ completed: \_\_\_\_\_

### Child's information

Child's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Child's last name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_ If child was born 3 or more weeks prematurely, # of weeks premature: \_\_\_\_\_ Child's gender:  Male  Female

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Street address: \_\_\_\_\_ Relationship to child:  Parent  Guardian  Teacher  Child care provider  Grandparent or other relative  Foster parent  Other: \_\_\_\_\_

City: \_\_\_\_\_ 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 #: \_\_\_\_\_ Age at administration in months and days: \_\_\_\_\_

Program ID #: \_\_\_\_\_ If premature, adjusted age in months and days: \_\_\_\_\_

Program name: \_\_\_\_\_



# 18 Month Questionnaire

17 months 0 days  
through 18 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:

### 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 \_\_\_\_\_.

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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. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When you ask your child to, does he go into another room to find a familiar toy or object? ( <i>You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket."</i> )	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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? ( <i>Mark "yes" even if her words are difficult to understand.</i> )	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" ( <i>He needs to identify only one picture correctly.</i> )	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? ( <i>Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?"</i> ) Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

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

## GROSS MOTOR

- |  | YES                   | SOMETIMES             | NOT YET               |                            |
|--|-----------------------|-----------------------|-----------------------|----------------------------|
| 1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                          |
| 2. Does your child move around by walking, rather than by crawling on her hands and knees?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                          |
| 3. Does your child walk well and seldom fall?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                          |
| 4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                          |
| 5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. <i>(You can look for this at a store, on a playground, or at home.)</i>                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                          |
| 6. 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? <i>(If your child already kicks a ball, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                          |
|  |                       |                       |                       | <b>GROSS MOTOR TOTAL</b> — |

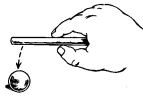
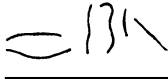



## FINE MOTOR

- |  | YES                   | SOMETIMES             | NOT YET               |                           |
|--|-----------------------|-----------------------|-----------------------|---------------------------|
| 1. Does your child throw a small ball with a forward arm motion? <i>(If he simply drops the ball, mark "not yet" for this item.)</i>                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                         |
| 2. Does your child stack a small block or toy on top of another one? <i>(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                         |
| 3. Does your child make a mark on the paper with the <b>tip</b> of a crayon (or pencil or pen) when trying to draw?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                         |
| 4. Does your child stack three small blocks or toys on top of each other by himself?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                         |
| 5. Does your child turn the pages of a book by himself? <i>(He may turn more than one page at a time.)</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                         |
| 6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —                         |
|  |                       |                       |                       | <b>FINE MOTOR TOTAL</b> — |



**PROBLEM SOLVING**

- |   | YES                   | SOMETIMES             | NOT YET               |   |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.)  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
| 2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
|   |                       |                       |                       |  |
| 3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.)   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
| 4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
|   |                       |                       |                       |  |
| 5. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
|   |                       |                       |                       |  |
| 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 him how.)   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___*  |

PROBLEM SOLVING TOTAL \_\_\_\_\_

*\*If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

**PERSONAL-SOCIAL**

- |  | YES                   | SOMETIMES             | NOT YET               |     |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. While looking at herself in the mirror, does your child offer a toy to her own image?                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child play with a doll or stuffed animal by hugging it?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your child get your attention or try to show you something by pulling on your hand or clothes?           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child drink from a cup or glass, putting it down again with little spilling?                        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?              | <input 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

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

YES

NO

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 her 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



# 18 Month ASQ-3 Information Summary

17 months 0 days through  
18 months 30 days

Child's name: \_\_\_\_\_ Date ASQ completed: \_\_\_\_\_

Child's ID #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	○	○	○	○	○	○	○	○

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

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