

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

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◆ **14 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.



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♦ **14 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: _____



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. Does your child say one word in addition to "Mama" and "Dada"?
(A "word" is a sound or sounds the baby says consistently to mean someone or something, such as "baba" for bottle.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When your child wants something, does she tell you by <i>pointing</i> to it? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your child shake his head when he means "no" or "yes"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child point to, pat, or try to pick up pictures in a book? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your child say four or more words in addition to "Mama" and "Dada"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. When you ask her 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." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

COMMUNICATION TOTAL ___

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

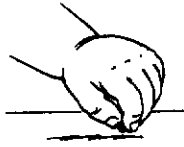
- | | | | | | |
|--|---|--------------------------|--------------------------|--------------------------|-----|
| 1. If you hold both hands just to balance him, does your child take several steps without tripping or falling? (If your child already walks alone, check "yes" for this item.) |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When you hold <i>one hand</i> just to balance her, does your child take several steps forward? (If your child already walks alone, check "yes" for this item.) |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your child stand up in the middle of the floor by himself and take several steps forward? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child climb onto furniture? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. Does your child move around by walking, rather than by crawling on his hands and knees? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

GROSS MOTOR TOTAL ___

YES SOMETIMES NOT YET

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

1. Without resting her arm or hand on the table, does your child pick up a crumb or Cheerio with the tip of her thumb and a finger?



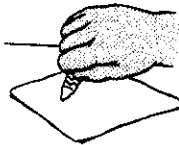
2. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, check "not yet" for this item.)



3. Does your child help turn the pages of a book? (You may lift a page for her to grasp.)

4. 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.)

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



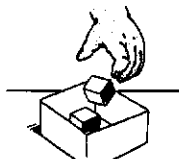
6. Does your child stack three small blocks or toys on top of each other by herself?

FINE MOTOR TOTAL _____

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

1. If you put a small toy into a bowl or box, does your child copy you by putting in a toy, although she may not let go of it? (If she already lets go of the toy into a bowl or box, check "yes" for this item.)

2. Does your child drop two small toys, one after the other, into a container like a bowl or box? (You may show him how to do it.)



 _____*

3. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your child copy you by scribbling? (If she already scribbles on her own, check "yes" for this item.)

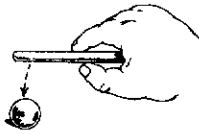
4. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?

5. 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.)

YES SOMETIMES NOT YET

PROBLEM-SOLVING *(continued)*

6. 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?



PROBLEM SOLVING TOTAL _____

"If problem solving item 2 is marked "yes" or "sometimes," mark problem solving item 1 as "yes."

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|-------|
| 1. When you dress her, does your child lift her foot for her shoe, sock, or pant leg? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Does your child roll or throw a ball back to you, so that you can return it to him? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Does your child play with a doll or stuffed animal by hugging it? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Does your child feed herself with a spoon, even though she may spill some food? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Does your child help undress himself by taking off clothes like socks, hat, shoes, or mittens? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

PERSONAL-SOCIAL TOTAL _____

OVERALL *Parents and providers may use the back of this sheet for additional comments.*

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you think your child hears well? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____ | | |
| 2. Does your child use both hands equally well? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____ | | |
| 3. When your child is standing, are her feet flat on the surface most of the time? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____ | | |
| 4. Does either parent have a family history of childhood deafness or hearing impairment? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |
| 5. Do you have concerns about your child's vision? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |
| 6. Has your child had any medical problems in the last several months? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |
| 7. Does anything about your child worry you? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |

14 Month ASQ Information Summary

Child's name: _____
 Person filling out the ASQ: _____
 Mailing address: _____
 Telephone: _____
 Today's date: _____

Date of birth: _____
 Corrected date of birth: _____
 Relationship to child: _____
 City: _____ State: _____ ZIP: _____
 Assisting in ASQ completion: _____

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 | 4. Family history of hearing impairment?
Comments: | YES NO |
| 2. Uses both hands equally well?
Comments: | YES NO | 5. Vision concerns?
Comments: | YES NO |
| 3. Child's feet flat on the surface?
Comments: | YES NO | 6. Recent medical problems?
Comments: | YES NO |
| | | 7. Other concerns?
Comments: | YES NO |

SCORING THE QUESTIONNAIRE

- 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*.
- 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
- Add up the item scores for each area, and record these totals in the space provided for area totals.
- 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.

Total	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross motor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine motor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem solving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-social	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total	0	5	10	15	20	25	30	35	40	45	50	55	60

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

- If the child's total score falls within the area, the child appears to be doing well in this area at this time.
- 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.

		Score	Cutoff	Communication	Gross motor	Fine motor	Problem solving	Personal-social
14 months	Communication		31.0	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Gross motor		24.0	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Fine motor		25.0	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Problem solving		28.5	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>	4 <input type="radio"/> <input type="radio"/> <input type="radio"/>
	Personal-social		22.5	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>	5 <input type="radio"/> <input type="radio"/> <input type="radio"/>
					6 <input type="radio"/> <input type="radio"/> <input type="radio"/>	6 <input type="radio"/> <input type="radio"/> <input type="radio"/>	6 <input type="radio"/> <input type="radio"/> <input type="radio"/>	6 <input type="radio"/> <input type="radio"/> <input type="radio"/>
				Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____