

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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♦ **22 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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◆ **22 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.*

- | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|-------|
| <p>1. 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?")</p> <p>Please give an example of your child's word combinations:</p> <hr/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>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 <i>name</i> at least one picture?</p> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>3. Without giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?</p> <p>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."</p> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>4. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least <i>seven</i> body parts? (She can point to part of herself, you, or a doll.)</p> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>5. Does your child say fifteen words or more in addition to "Mama" and "Dada"?</p> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?</p> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| COMMUNICATION TOTAL | | | | <hr/> |

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

- | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|-------|
| <p>1. 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.)</p> |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>2. Does your child run fairly well, stopping herself without bumping into things or falling?</p> |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>3. Does your child walk down stairs if you hold onto one of his hands? (You can look for this at a store, on a playground, or at home.)</p> |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |
| <p>4. Does your child walk either up or down at least two steps by herself? You can look for this at a store, on a playground, or at home. (Check "yes" even if she holds onto the wall or railing.)</p> |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> |

YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

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



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



 _____*

GROSS MOTOR TOTAL _____

"If gross motor item 6 is marked "yes" or "sometimes," mark gross motor item 1 as "yes."

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

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

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

3. 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?

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

5. Does your child flip light switches off and on?

6. Does your child thread a shoelace through either a bead or an eyelet of a shoe?



FINE MOTOR TOTAL _____

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

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

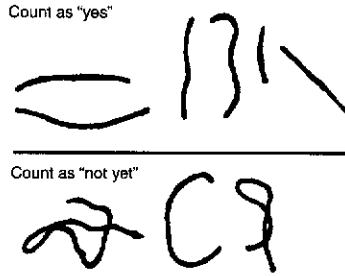
2. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up at least *two* blocks side by side? (You can also use spools of thread, small boxes, or other toys.)



3. 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 his head, pretending it is a hat? Does he use a block or small toy to stir food?

PROBLEM SOLVING *(continued)*

4. After she 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.")



5. Without showing him how, does your child purposefully turn a small, clear bottle upside down to dump out a crumb or Cheerio? (You can use a soda-pop bottle or baby bottle.)

6. If you give your child a bottle, spoon, or pencil upside down, does she turn it right side up so that she can use it properly?

PROBLEM SOLVING TOTAL _____

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

1. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

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

- a. Open and close your mouth.
- b. Blink your eyes.
- c. Pull on your earlobe.
- d. Pat your cheek.

3. Does your child eat with a fork?

4. Does your child drink from a cup or glass, putting it down again with little spilling?

5. When playing with either a stuffed animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?

6. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if he cannot turn?

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 her age?

YES NO

If no, explain: _____

OVERALL (continued)

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 his 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: _____
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: _____

22 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.

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

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
22 months	Communication	<input type="checkbox"/>	35.0	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Gross motor	<input type="checkbox"/>	40.0	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Fine motor	<input type="checkbox"/>	36.5	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Problem solving	<input type="checkbox"/>	36.5	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Personal-social	<input type="checkbox"/>	39.5	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
					6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____