

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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27 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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27 Month
Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

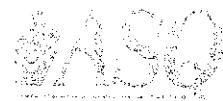
Your mailing address: _____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

Administering program or provider: _____



YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

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



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



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.) He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)



 _____*

GROSS MOTOR TOTAL _____

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

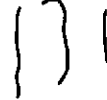
FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child 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 light switches off and on?

3. After he watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask your child 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?

Count as "yes"



Count as "not yet"



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.)

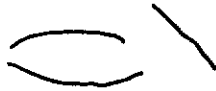
5. Does your child thread a shoelace through either a bead or eyelet of a shoe?



FINE MOTOR *(continued)*

6. After she watches you draw a line from one side of the paper to the other side, ask your child 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?

Count as "yes"



Count as "not yet"



FINE MOTOR TOTAL _____

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

1. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?

2. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his 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 her image in the mirror?

4. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it?

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.)



6. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person? Responses like "snowman," "boy," "man," "girl," and "Daddy" are correct.



Please write your child's response here:

PROBLEM SOLVING TOTAL _____

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

1. 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.

YES SOMETIMES NOT YET

PERSONAL-SOCIAL *(continued)*

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-----|
| 2. Does your child eat with a fork? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if he cannot turn? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 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." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. Does your child put on a coat, jacket, or shirt by himself? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

PERSONAL-SOCIAL TOTAL ___

OVERALL *Parents and providers may use the space below or 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. Do you think your child talks like other toddlers her age? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____ | | |
| 3. Can you understand most of what your child says? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____ | | |
| 4. Do you think your child walks, runs, and climbs like other toddlers his age? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____ | | |
| 5. Does either parent have a family history of childhood deafness or hearing impairment? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |
| 6. Do you have concerns about your child's vision? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |
| 7. Has your child had any medical problems in the last several months? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |
| 8. Does anything about your child worry you? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____ | | |

27 Month ASQ Information Summary

Child's name: _____ Date of birth: _____
 Person filling out the ASQ: _____ Relationship to child: _____
 Mailing address: _____ 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

- 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.

27 months	Score	Cutoff	Communication			Gross motor			Fine motor			Problem solving			Personal-social		
			1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Communication		33.5	<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"/>	<input type="radio"/>	<input type="radio"/>
Gross motor		35.0	<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"/>	<input type="radio"/>	<input type="radio"/>
Fine motor		26.0	<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"/>	<input type="radio"/>	<input type="radio"/>
Problem solving		37.0	<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"/>	<input type="radio"/>	<input type="radio"/>
Personal-social		33.0	<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"/>	<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: _____

