

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition

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◆ **20 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 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? (Check "yes" even if her words are difficult to understand.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. Does your child say eight words or more in addition to "Mama" and "Dada"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Without showing him first, does your child <i>point</i> to the correct picture when you say, "Show me the kitty" or ask, "Where is the ball?" (He needs to identify only one picture correctly.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. 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?") | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

Please give an example of your child's word combinations:

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|-----|
| 5. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. Without giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> 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." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

COMMUNICATION TOTAL ___

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

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your child climb on an object such as a chair to reach something he wants? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. Does your child walk well and seldom fall? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your child walk down stairs if you hold onto one of her hands? (You can look for this at a store, on a playground, or at home.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your child run fairly well, stopping herself without bumping into things or falling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |



YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

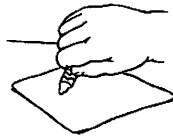
6. Does your child walk either up or down at least two steps by himself? You can look for this at a store, on a playground, or at home. (Check "yes" even if he holds onto the wall or railing.)



GROSS MOTOR TOTAL _____

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

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



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

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

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

5. Does your child stack six small blocks or toys on top of each other by himself?

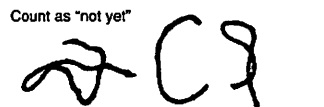
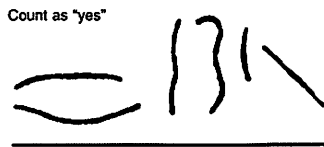
6. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

FINE MOTOR TOTAL _____

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

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

2. 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.")



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

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

YES SOMETIMES NOT YET

PROBLEM SOLVING *(continued)*

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

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 at least *two* blocks side by side? (You can also use spools of thread, small boxes, or other toys.)



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

PROBLEM SOLVING TOTAL _____

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

1. Does your child feed himself with a spoon, even though he may spill some food? _____

2. Does your child get your attention or try to show you something by pulling on your hand or clothes? _____

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

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

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 eat with a fork? _____

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: _____

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?
If yes, explain: _____

YES NO

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

YES NO

7. Has your child had any medical problems in the last several months?
If yes, explain: _____

YES NO

8. Does anything about your child worry you?
If yes, explain: _____

YES NO

OVERALL (continued)

20 Month ASQ Information Summary

Child's name: _____ Date of birth: _____
 Person filling out the ASQ: _____ Corrected date of birth: _____
 Mailing address: _____ Relationship to child: _____
 Telephone: _____ City: _____ State: _____ ZIP: _____
 Today's date: _____ 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 |
|-----------|-----------------|--------------------------|--------|---|---|---|---|---|
| 20 months | Communication | <input type="checkbox"/> | 36.3 | 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 | <input type="checkbox"/> | 36.2 | 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 | <input type="checkbox"/> | 39.8 | 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 | <input type="checkbox"/> | 29.9 | 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 | <input type="checkbox"/> | 35.2 | 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: _____