

**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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◆ **33 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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◆ **33 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

**COMMUNICATION**

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

1. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll.)
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------
2. Does your child make sentences that are three or four words long?
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Please give an example:

\_\_\_\_\_

\_\_\_\_\_

3. Without giving him help by pointing or using gestures, ask your child to "Put the shoe on the table" and "Put the book under the chair." Does your child carry out both of these directions correctly?
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------
4. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture? (For example, "Barking," "Running," "Eating," and "Crying") You may ask, "What is the dog (or boy) doing?"
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle, and ask your child to move the zipper down. Return the zipper to the middle, and ask your child to move the zipper up. Do this several times, placing the zipper in the middle before asking your child to move it up or down. Does your child consistently move the zipper up when you say "up" and down when you say "down"?
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------
6. When you ask, "What is your name?" does your child say both her first and last names?
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

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

**GROSS MOTOR**

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


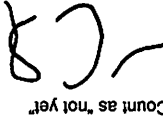



1. Does your child run fairly well, stopping herself without bumping into things or falling?
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------
2. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?
 




<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------
3. Does your child jump with both feet leaving the floor at the same time?
 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------



1. 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" 
2. Does your child thread a shoelace through either a bead or an eyelet of a shoe?
- 
3. 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** Be sure to try each activity with your child.

4. 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.) She may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)
- 
5. Does your child stand on one foot for about 1 second without holding onto anything?
- 
6. While standing, does your child throw a ball overhand by raising his arm to shoulder height and throwing the ball forward? (Dropping the ball or throwing the ball underhand does not count.)
- 

GROSS MOTOR TOTAL

—

—

—

YES    SOMETIMES    NOT YET

**GROSS MOTOR** (continued)

YES      SOMETIMES      NOT YET

**FINE MOTOR**      *(continued)*

4. After he watches you draw a single circle, ask your child to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle? Count as "yes"



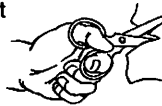
Count as "not yet"



                 \_\_\_\_\_

5. Does your child turn pages in a book, one page at a time?                   \_\_\_\_\_

6. Does your child try to cut paper with child-safe scissors? She does not need to cut the paper but must get the blades to open and close while holding the paper with the other hand. (You may show your child how to use scissors. Carefully watch your child's use of scissors for safety reasons.)



                 \_\_\_\_\_

FINE MOTOR TOTAL \_\_\_\_\_

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

1. When looking in the mirror, ask, "Where is \_\_\_\_\_?" (Use your child's name.) Does your child point to her image in the mirror?



                 \_\_\_\_\_

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 four objects in a row? (You can also use spools of thread, small boxes, or other toys.)



                 \_\_\_\_\_

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

4. 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:

\_\_\_\_\_

5. When you say, "Say seven three," does your child repeat just the two numbers in the correct order? *Do not repeat the numbers.* If necessary, try another pair of numbers and say, "Say eight two." Your child must repeat just one series of two numbers for you to answer "yes" to this question.                   \_\_\_\_\_

6. After she draws a "picture," even a simple scribble, does your child tell you what she drew? You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.                   \_\_\_\_\_

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

YES      SOMETIMES      NOT YET

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

- |  |                          |                          |                          |     |
|--|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your child use a spoon to feed herself with little spilling?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. 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"/> | ___ |
| 3. Does your child put on a coat, jacket, or shirt by herself?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. After you put on loose-fitting pants around his feet, does your child pull them completely up to his waist?                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. When she is looking in a mirror and you ask, "Who is in the mirror?" does your child say either "Me" or her own name?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?                                     | <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?<br>If no, explain: _____  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. Do you think your child talks like other toddlers her age?<br>If no, explain: _____                             | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. Can you understand most of what your child says?<br>If no, explain: _____                                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. Do you think your child walks, runs, and climbs like other toddlers his age?<br>If no, explain: _____           | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5. Does either parent have a family history of childhood deafness or hearing impairment?<br>If yes, explain: _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. Do you have concerns about your child's vision?<br>If yes, explain: _____                                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7. Has your child had any medical problems in the last several months?<br>If yes, explain: _____                   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8. Does anything about your child worry you?<br>If yes, explain: _____   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

# 33 Month ASQ Information Summary

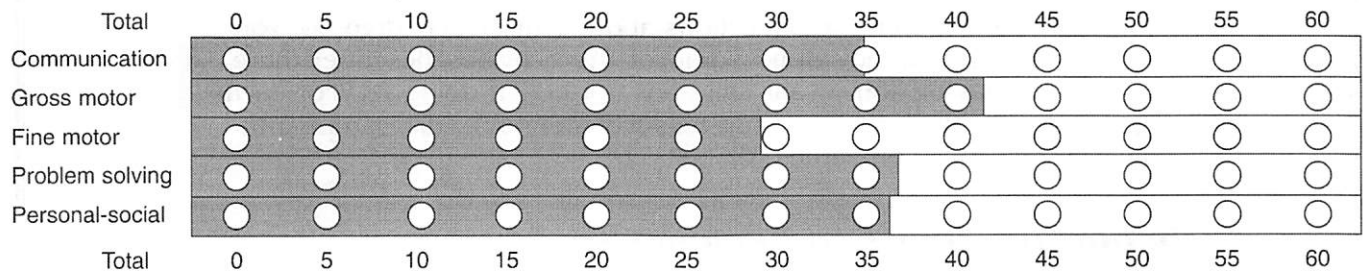
Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Person filling out the ASQ: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Assisting in ASQ completion: \_\_\_\_\_  
 Today's date: \_\_\_\_\_

**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 children? 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.



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
33 months	Communication	<input type="checkbox"/>	35.0	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
				2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
	Gross motor	<input type="checkbox"/>	41.5	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
				4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
	Fine motor	<input type="checkbox"/>	29.5	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
				6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>
				Y S N	Y S N	Y S N	Y S N	
				Y S N	Y S N	Y S N	Y S N	
				Y S N	Y S N	Y S N	Y S N	Y S N
				Y S N	Y S N	Y S N	Y S N	Y S N
				Y S N	Y S N	Y S N	Y S N	Y S N
				Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: \_\_\_\_\_

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