

**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System**

By Diane Bricker, Jane Squires, and Linda Mounts  
with assistance from LaWanda Potter, Robert Nickel, and Jane Farrell

Copyright © 1995 by Paul H. Brookes Publishing Co.

♦ **30 Month** ♦  
**Questionnaire**

Please fill out the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Who is 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: \_\_\_\_\_

Today's date: \_\_\_\_\_

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



YES      SOMETIMES      NOT YET

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




1. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?                   \_\_\_\_\_
  
2. Without giving him clues by pointing or using gestures, can your child carry out at least *three* 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."  |

                  \_\_\_\_\_
  
3. 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.)                   \_\_\_\_\_
  
4. Does your child make sentences that are three or four words long? Please give an example:  
 \_\_\_\_\_  
 \_\_\_\_\_  
                  \_\_\_\_\_
  
5. 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?                   \_\_\_\_\_
  
6. When looking at a picturebook, 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?"                   \_\_\_\_\_




COMMUNICATION TOTAL      \_\_\_\_\_

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

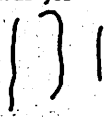
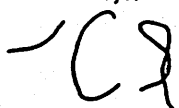

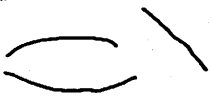

1. Does your child run fairly well, stopping herself without bumping into things or falling?                   \_\_\_\_\_

  
2. 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.)                   \_\_\_\_\_

  
3. Without holding onto anything for support, can your child kick a ball by swinging her leg forward?                   \_\_\_\_\_


YES      SOMETIMES      NOT YET

**GROSS MOTOR**      *(continued)*

- |   |   |                          |                          |                          |  |
|---|---|--------------------------|--------------------------|--------------------------|--|
| <p>4. Does your child jump with both feet leaving the floor at the same time?</p>   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |
| <p>5. Does your child walk up stairs, using only one foot on each stair? The left foot on one step and the right foot 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.)</p> |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |
| <p>6. Does your child stand on one foot for about 1 second without holding onto anything?</p>   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |
| <p><b>GROSS MOTOR TOTAL</b></p>   |   |                          |                          |                          | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |

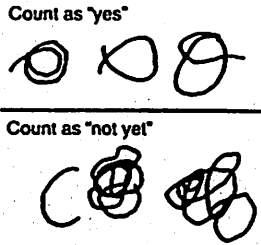
**FINE MOTOR**      *Be sure to try each activity with your child.*

- |   |  |                          |                          |                          |  |
|---|--|--------------------------|--------------------------|--------------------------|--|
| <p>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?</p>   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |
| <p>2. 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?</p> | <p style="font-size: small;">Count as "yes"</p>  <hr style="width: 100%; border: 0; border-top: 1px solid black;"/> <p style="font-size: small;">Count as "not yet"</p>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |
| <p>3. Does your child thread a shoelace either through a bead or an eyelet of a shoe?</p>   |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |
| <p>4. 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?</p>                       | <p style="font-size: small;">Count as "yes"</p>  <hr style="width: 100%; border: 0; border-top: 1px solid black;"/> <p style="font-size: small;">Count as "not yet"</p>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr style="width: 20px; border: 0; border-top: 1px solid black;"/> |

YES      SOMETIMES      NOT YET

**FINE MOTOR**      *(continued)*

5. 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?



                 \_\_\_\_\_

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

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?                   \_\_\_\_\_

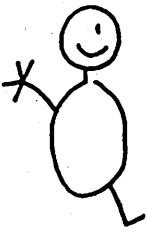
2. If your child wants something he cannot reach, does he go and find a chair or box to stand on to reach it?                   \_\_\_\_\_

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



                 \_\_\_\_\_

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. 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.       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your child use a spoon to feed himself with little spilling?  |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if she cannot turn? |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child put on a coat, jacket, or shirt by himself?  |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?                                |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. When he is looking in a mirror and you ask, "Who is in the mirror?" does your child say either "Me" or his own name?                       |                          | <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. Do you think your child talks like other children 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 children his age?            | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____  |                              |                             |
| 5. Does either parent have any family history of childhood deafness or hearing impairment? | 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: _____   |                              |                             |

# 30 Month ASQ Information Summary

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Who is 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 parents' comments.

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

## SCORING THE QUESTIONNAIRE

- Be sure each question has been answered. If a question 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          |
|--------------|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 30 months    | Communication   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | Gross motor     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | Fine motor      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | Problem solving | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | Personal-social | <input type="checkbox"/> | <input type="checkbox"/> | <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: \_\_\_\_\_