

15 Month Pre-Visit Questionnaire

Instructions: Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health

1 Do you have concerns about your child's health?	NO	YES
2 Has your child had any problems with shots or immunizations?	NO	YES

Review of Systems

3 Do you have any concerns about your child's hearing?	NO	YES
4 Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

5 Is your child breastfeeding?	YES	NO
a. How often?		
6 Is your child taking formula or milk well?	YES	NO
a. Which kind of milk or formula?		
b. How much milk per day?		
7 Does your child eat fruits or vegetables at every meal?	YES	NO
8 Do you feed your child mostly whole grains?	YES	NO
9 Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
10 Does your child still drink from a bottle?	NO	YES
11 Does your child drink juice or other sweetened drinks?	NO	YES
12 Do you give your child any vitamins or supplements?	NO	YES
13 Does your child snack more than 2 times a day?	NO	YES

Oral Health

14 Does your child fall asleep with a bottle and/or wake at night to breast or bottle feed?	NO	YES
15 Are you using a soft toothbrush or cloth to clean your child's teeth and 2 times per day?	YES	NO
16 Do you have a dentist for your child?	YES	NO
17 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
18 Does your child only drink milk at meals?	YES	NO

Elimination

19 Does your child have any problems with bowel movements (pooping)?	NO	YES
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Activity / Exercise / Screen Time

20 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
21 Do you play with your child every day?	YES	NO
22 Do you read to your child every day?	YES	NO

Sleep

23 Does your child sleep through the night?	YES	NO
24 Do you have a bedtime routine?	YES	NO
25 Does your child fall asleep on his own, in his/her own bed?	YES	NO

Development

(If you are completing the Ages and Stages questionnaire please skip this section)

26 Does your child know at least one body part?	YES	NO
27 Does your child let you know when he/she wants something?	YES	NO
28 Does your child bring things over to show you?	YES	NO
29 Does your child babble a lot?	YES	NO
30 Does your child say 4-5 words clearly?	YES	NO
31 Does your child understand and follow simple commands?	YES	NO
32 Does your child walk well?	YES	NO
33 Can your child scribble?	YES	NO
34 Does your child copy things you do?	YES	NO

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35 Can your child listen to a story?	YES	NO
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Social Stressors

36 Do you feel you receive the support you need?	YES	NO	
37 Have there been any major changes or stresses in your family recently?	NO	YES	
38 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
39 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
40 Does anyone in your life ever hurt you or your children?	NO	YES	

Behavior

41 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
42 Do you praise your child when he/she is behaving well?	YES	NO

Safety

43 Is the crib mattress at the lowest position?	YES	NO	
44 Does anyone smoke or vape around your child?	NO	YES	
45 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
46 Do you keep plastic bags and latex balloons away from your child?	YES	NO	
47 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO	
48 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO	
49 Are you using a shade or sunscreen if your child is in the sun more than 15-30 minutes?	YES	NO	
50 If there is a swimming pool, pond or lake near your home, is it secured so that your child cannot access it?	N/A	YES	NO

Lead

51 Is your child regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
52 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES



16 Month Questionnaire

15 months 0 days
through 16 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☒ Try each activity with your baby before marking a response.
- ☒ Make completing this questionnaire a game that is fun for you and your child.
- ☒ Make sure your child is rested and fed.
- ☒ Please return this questionnaire by _____.

Notes:

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, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your child point to, pat, or try to pick up pictures in a book?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child say four or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. 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? (Mark "yes" even if her words are difficult to understand.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

COMMUNICATION TOTAL

—

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child stand up in the middle of the floor by himself and take several steps forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child climb onto furniture or other large objects, such as large climbing blocks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

GROSS MOTOR

(continued)

	YES	SOMETIMES	NOT YET	
4. Does your child move around by walking, rather than crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
GROSS MOTOR TOTAL				—

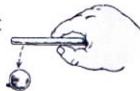
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child help turn the pages of a book? (You may lift a page for her to grasp.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child stack three small blocks or toys on top of each other by herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
FINE MOTOR TOTAL				—

**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET	
1. After you scribble back and forth on paper with a crayon (or pencil or pen), does your child copy you by scribbling? (If she already scribbles on her own, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING (continued)

4. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? 
5. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?
6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump it out? (You may show her how.)

YES	SOMETIMES	NOT YET	
<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 TOTAL

*If Problem Solving Item 5 is marked "yes," mark Problem Solving Item 1 as "yes."

PERSONAL-SOCIAL

1. Does your child feed himself with a spoon, even though he may spill some food?
2. Does your child help undress herself by taking off clothes like socks, hat, shoes, or mittens?
3. Does your child play with a doll or stuffed animal by hugging it?
4. While looking at himself in the mirror, does your child offer a toy to his own image?
5. Does your child get your attention or try to show you something by pulling on your hand or clothes?
6. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?

YES	SOMETIMES	NOT YET	
<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"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PERSONAL-SOCIAL TOTAL

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:

☐ YES ☐ NO

OVERALL (continued)

2. Do you think your child talks like other toddlers his age? If no, explain:

☐ YES☐ NO

3. Can you understand most of what your child says? If no, explain:

☐ YES☐ NO

4. Do you think your child walks, runs, and climbs like other toddlers her age?
If no, explain:

☐ YES☐ NO

5. Does either parent have a family history of childhood deafness or hearing
impairment? If yes, explain:

☐ YES☐ NO

6. Do you have 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

OVERALL (continued)

8. Do you have any concerns about your child's behavior? If yes, explain:

☐ YES☐ NO

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

☐ YES☐ NO



16 Month ASQ-3 Information Summary

15 months 0 days through
16 months 30 days

Child's name: _____ Date ASQ completed: _____
Child's ID #: _____ Date of birth: _____
Administering program/provider: _____ Was age adjusted for prematurity
when selecting questionnaire? ☐ Yes ☐ No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	16.81		<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	37.91		<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	31.98		<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	30.51		<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	26.43		<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"/>

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|--|-----|---------------|--|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Concerns about vision?
Comments: | YES | No |
| 2. Talks like other toddlers his age?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Walks, runs, and climbs like other toddlers?
Comments: | Yes | NO | 9. Other concerns?
Comments: | YES | No |
| 5. Family history of hearing impairment?
Comments: | | YES No | | | |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ☐ area, it is above the cutoff, and the child's development appears to be on schedule.

If the child's total score is in the ☐ area, it is close to the cutoff. Provide learning activities and monitor.

If the child's total score is in the ☐ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- _____ Provide activities and rescreen in _____ months.
_____ Share results with primary health care provider.
_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
_____ Refer to primary health care provider or other community agency (specify reason): _____
_____ Refer to early intervention/early childhood special education.
_____ No further action taken at this time
_____ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						