

2 Year 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
3 Does your child receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

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

Feeding/Nutrition

6 Is your child drinking milk?	YES	NO
a. What kind of milk?		
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 Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
10 Does your child snack more than 2 times a day?	NO	YES
11 Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
12 Is your child drinking from a bottle?	NO	YES
13 Does your child drink juice or other sweetened drinks?	NO	YES
14 Do you give your child any vitamins or supplements?	NO	YES
15 Are you worried about your child's weight?	NO	YES

Lipids

16 Does your child have parents or grandparents with stroke or heart attack before age 55?	NO	YES
17 Does your child have a parent with high cholesterol or on cholesterol medication?	NO	YES

Oral Health

18 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
19 Do you have a dentist for your child?	YES	NO
20 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

21 Does your child have regular soft bowel movements (poop)?	YES	NO
22 Have you started toilet (potty) training?	YES	NO
23 Does your child tell you when a diaper needs to be changed?	YES	NO

Activity / Exercise / Screen Time

24 Does your child have screen time (smartphone, tablet, TV) more than 1 hour daily?	NO	YES
25 Does your child have bedroom access to screen time?	NO	YES
26 Do you read to your child every day?	YES	NO
27 Does your child play actively for at least 1 hour per day?	YES	NO

Sleep

28 Does your child sleep through the night?	YES	NO
29 Do you have a bedtime routine?	YES	NO
30 Does your child fall asleep on his own, in his/her own bed?	YES	NO
31 Does your child snore more than a little?	NO	YES

Social Stressors

32 Do you feel you receive the support you need?	YES	NO	
33 Have there been any major changes or stresses in your family recently?	NO	YES	
34 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
35 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES

Behavior

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

Development

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

38 Does your child have a fifty word vocabulary?	YES	NO
39 Does your child use 2-3 word phrases or sentences ("More milk" or "Hi Mom")	YES	NO
40 Does your child know 6 or more body parts?	YES	NO
41 Does your child copy things you do?	YES	NO
42 Does your child follow 2 step instructions?	YES	NO
43 Does your child walk up and down stairs while holding on?	YES	NO
44 Does your child turn pages one at a time?	YES	NO
45 Can your child name some pictures in books?	YES	NO
46 Can your child hold a cup with one hand?	YES	NO
47 Can your child jump with both feet on the floor?	YES	NO
48 Can your child throw a ball overhand?	YES	NO
49 Can your child kick a ball?	YES	NO
50 Does your child try to write with a pencil?	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

Safety

53 Is the crib mattress at the lowest position?	YES	NO	
54 Does anyone smoke or vape around your child?	NO	YES	
55 Do you keep your child away from cars, trucks, lawn mowers, driveways, and streets?	YES	NO	
56 Do you watch your child when he/she plays outside?	YES	NO	
57 Does your child wear a helmet when on a tricycle or bicycle?	YES	NO	
58 If there is a gun in the home, is it locked in a safe with the ammunition stored separately?	N/A	YES	NO
59 Does your child ride in a safety seat, in the back seat?	YES	NO	
60 Do you have the number for Poison Control?	YES	NO	
61 Do you put sunscreen on your child when in the sun for more than 15-30 minutes?	YES	NO	

Tuberculosis

62 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
63 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
64 Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
65 Has your child traveled to a high-risk country for more than a week?	NO	YES



24 Month Questionnaire

23 months 0 days
through 25 months 15 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. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (She needs to identify only one picture correctly.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. 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"/> | _____ |
| 3. Without your giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| <input type="radio"/> a. "Put the toy on the table." | | | | |
| <input type="radio"/> b. "Close the door." | | | | |
| <input type="radio"/> c. "Bring me a towel." | | | | |
| <input type="radio"/> d. "Find your coat." | | | | |
| <input type="radio"/> e. "Take my hand." | | | | |
| <input type="radio"/> f. "Get your book." | | | | |
| 4. 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="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. 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?") Please give an example of your child's word combinations: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

COMMUNICATION

(continued)

6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?

YES

SOMETIMES

NOT YET

☐☐☐

COMMUNICATION TOTAL

GROSS MOTOR

1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)

YES

SOMETIMES

NOT YET

☐☐☐

2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "yes" for this item.)

☐☐☐

3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.

☐☐☐

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

☐☐☐

5. Does your child jump with both feet leaving the floor at the same time?

☐☐☐

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

☐☐☐

GROSS MOTOR TOTAL

*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."

FINE MOTOR

1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?
2. Does your child turn the pages of a book by herself? (*She may turn more than one page at a time.*)
3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?
4. Does your child flip switches off and on?
5. 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.*)
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

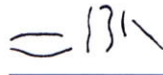


YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input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

PROBLEM SOLVING

1. After watching 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? (*Mark "not yet" if your child scribbles back and forth.*)
2. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (*Do not show him how.*) (*You can use a soda-pop bottle or baby bottle.*)
3. 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?
4. 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?
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?

Count as "yes"



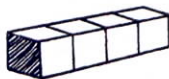
Count as "not yet"



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"/>	—

PROBLEM SOLVING (continued)

6. 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.)



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

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

- Does your child drink from a cup or glass, putting it down again with little spilling?
- Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?
- Does your child eat with a fork?
- When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?
- Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?
- 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."

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

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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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

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

☐ YES ☐ NO

OVERALL (continued)

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 his 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 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

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



24 Month ASQ-3 Information Summary

23 months 0 days through
25 months 15 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

- 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	25.17		●	●	●	●	●	●	●	●	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

- 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						



Child's name _____
Age _____

Date _____
Relationship to child _____

M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

- | | Yes | No |
|--|-----|----|
| 1. If you point at something across the room, does your child look at it?
(FOR EXAMPLE , if you point at a toy or an animal, does your child look at the toy or animal?) | | |
| 2. Have you ever wondered if your child might be deaf? | | |
| 3. Does your child play pretend or make-believe? (FOR EXAMPLE , pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) | | |
| 4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs) | | |
| 5. Does your child make <u>unusual</u> finger movements near his or her eyes?
(FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?) | | |
| 6. Does your child point with one finger to ask for something or to get help?
(FOR EXAMPLE , pointing to a snack or toy that is out of reach) | | |
| 7. Does your child point with one finger to show you something interesting?
(FOR EXAMPLE , pointing to an airplane in the sky or a big truck in the road) | | |
| 8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?) | | |
| 9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE , showing you a flower, a stuffed animal, or a toy truck) | | |
| 10. Does your child respond when you call his or her name? (FOR EXAMPLE , does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) | | |
| 11. When you smile at your child, does he or she smile back at you? | | |
| 12. Does your child get upset by everyday noises? (FOR EXAMPLE , does your child scream or cry to noise such as a vacuum cleaner or loud music?) | | |
| 13. Does your child walk? | | |
| 14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? | | |
| 15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do) | | |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at? | | |
| 17. Does your child try to get you to watch him or her? (FOR EXAMPLE , does your child look at you for praise, or say “look” or “watch me”?) | | |
| 18. Does your child understand when you tell him or her to do something?
(FOR EXAMPLE , if you don't point, can your child understand “put the book on the chair” or “bring me the blanket”?) | | |
| 19. If something new happens, does your child look at your face to see how you feel about it?
(FOR EXAMPLE , if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) | | |
| 20. Does your child like movement activities?
(FOR EXAMPLE , being swung or bounced on your knee) | | |