

4 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
6	Do you have any concerns about allergies?	NO	YES

Feeding/Nutrition

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 child eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese)?	YES	NO
10	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
11	Does your child snack more than 2 times a day?	NO	YES
12	Does your child drink soda, juice, or other sweetened drinks more than once or twice per week?	NO	YES
13	Do you give your child any vitamins or supplements?	NO	YES
14	Are you worried about your child's weight?	NO	YES

Lipids

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

Oral Health

17 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
18 Does your child see a dentist at least twice a year?	YES	NO
19 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

20 Does your child have regular soft bowel movements (poop)?	YES	NO
21 Is your child potty trained during the day?	YES	NO

School

22 Is your child in preschool?	YES	NO
23 Do you have any concerns about learning or school behavior?	NO	YES

Activity / Exercise / Screen Time

24 Does your child have more than 1 hour of screen time per day (TV, smartphones, tablets)?	NO	YES
25 Does your child have any screen time in his/her bedroom?	NO	YES
26 Do you read to your child every day?	YES	NO
27 Do you and your family do active and educational activities like walking, bicycling, swimming, going to libraries or going on nature walks?	YES	NO
28 Do you eat meals together as a family?	YES	NO
29 Does your child play actively for at least 1 hour every day	YES	NO

Sleep

30 Do you have concerns about your child's sleep?	NO	YES
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
38 Do you give your child choices?	YES	NO

Development

39 Does your child talk well, using long meaningful sentences?	YES	NO
40 Can other people can fully understand what your child is saying?	YES	NO
41 Does your child know his/her full name, telephone number, and 911?	YES	NO
42 Does your child make up stories, fantasies, situations?	YES	NO
43 Can your child skip or hop on one foot 4-5 times?	YES	NO
44 Does your child know 4 or more colors?	YES	NO
45 Can your child count to 10?	YES	NO
46 Can your child stack 8 or more blocks?	YES	NO
47 Can your child draw a person with at least 3 body parts?	YES	NO
48 Can you child copy a cross?	YES	NO
49 Can your child dress him/herself without supervision?	YES	NO

Safety

50 Do you talk to your child about stranger safety?	YES	NO	
51 Does your child know that private parts are private?	YES	NO	
52 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO	
53 Does anyone smoke or vape around your child?	NO	YES	
54 If there is a gun in the home, is it locked in a safe with ammunition stored separately	N/A	NO	YES
55 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO	
56 Do you put sunscreen on your child when outside for a long time?	YES	NO	
57 Do you ever leave your child alone in the car, house, or yard?	NO	YES	
58 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
59 Do you have a home fire escape plan?	YES	NO	

Tuberculosis

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



48 Month Questionnaire

45 months 0 days
through 50 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:

COMMUNICATION

YES SOMETIMES NOT YET

1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?

☐ ☐ ☐ _____

2. Does your child answer the following questions? (Mark "sometimes" if your child answers only one question.)

☐ ☐ ☐ _____

"What do you do when you are hungry?" (Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.") Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.") Please write your child's response:

3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?

☐ ☐ ☐ _____

4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?

☐ ☐ ☐ _____

COMMUNICATION

(continued)

5. Without your giving help by pointing or repeating, does your child follow three directions that are *unrelated* to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I am going to the park," or "Is there a toy to play with?" or "Are you coming, too?"

YES SOMETIMES NOT YET

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

COMMUNICATION TOTAL

—

GROSS MOTOR

YES SOMETIMES NOT YET

1. Does your child catch a large ball with both hands? (You should stand about 5 feet away and give your child two or three tries before you mark the answer.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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3. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. (Dropping the ball or throwing the ball underhand should be scored as "not yet.")



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? (You may give your child two or three tries before you mark the answer.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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GROSS MOTOR TOTAL

—

FINE MOTOR

YES SOMETIMES NOT YET

1. Does your child put together a five- to seven-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)

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

(continued)

2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.)



3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? (Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)

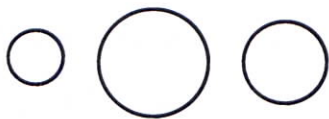


4. Does your child unbutton one or more buttons? (Your child may use his own clothing or a doll's clothing.)
5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?
6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? (Your child should not go more than 1/4 inch outside the lines on most of the picture.)

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"/>	—
FINE MOTOR TOTAL			—

PROBLEM SOLVING

1. When you say, "Say 'five eight three,'" does your child repeat *just* the three numbers in the same order? *Do not repeat the numbers.* If necessary, try another series of numbers and say, "Say 'six nine two.'" (Your child must repeat *just one series of three numbers* to answer "yes" to this question.)
2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? (Ask this question *without providing help by pointing, gesturing, or looking at the smallest circle.*)



3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "under the couch." Then ask her to put the ball "between the chairs" and the book "in the middle of the table."
4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? (Mark "yes" only if your child answers the question correctly using five colors.)

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"/>	—

PROBLEM SOLVING (continued)

5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure.
6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? (Ask this question without providing help by pointing, gesturing, or naming.)

YES SOMETIMES NOT YET

☐ ☐ ☐ —

☐ ☐ ☐ —

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?

YES SOMETIMES NOT YET

☐ ☐ ☐ —

2. Does your child tell you at least four of the following? Please mark the items your child knows.

☐ ☐ ☐ —

- ☐ a. First name ☐ d. Last name
- ☐ b. Age ☐ e. Boy or girl
- ☐ c. City she lives in ☐ f. Telephone number

3. Does your child wash his hands using soap and water and dry off with a towel without help?

☐ ☐ ☐ —

4. Does your child tell you the names of two or more playmates, not including brothers and sisters? (Ask this question without providing help by suggesting names of playmates or friends.)

☐ ☐ ☐ —

5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? (You may still need to check and rebrush your child's teeth.)

☐ ☐ ☐ —

6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)?

☐ ☐ ☐ —

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 children her age? If no, explain:

☐ YES☐ NO

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

☐ YES☐ NO

4. Can other people understand most of what your child says? If no, explain:

☐ YES☐ NO

5. Do you think your child walks, runs, and climbs like other children his age?
If no, explain:

☐ YES☐ NO

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

☐ YES☐ NO

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

☐ YES☐ NO

OVERALL (continued)

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

☐ YES☐ NO

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

☐ YES☐ NO

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

☐ YES☐ NO



48 Month ASQ-3 Information Summary

45 months 0 days through
50 months 30 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	30.72		<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	32.78		<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	15.81		<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"/>
Problem Solving	31.30		<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	26.60		<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. Family history of hearing impairment?
Comments: | YES | No |
| 2. Talks like other children his age?
Comments: | Yes | NO | 7. Concerns about vision?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Any medical problems?
Comments: | YES | No |
| 4. Others understand most of what your child says?
Comments: | Yes | NO | 9. Concerns about behavior?
Comments: | YES | No |
| 5. Walks, runs, and climbs like other children?
Comments: | Yes | NO | 10. Other concerns?
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						