



Date: _____

DEMOGRAPHICS

First Name _____ Last Name _____

Date of Birth _____ Gender _____ Marital status _____

SSN _____ Race _____ Ethnicity _____

Address _____ City _____

State _____ Zip Code _____ Email _____

Cell Phone _____ Home Phone _____ Work Phone _____

Guardian First name _____ Guardian Last name _____

Guardian Gender _____ Guardian DOB _____

Guardian Relationship _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

Emergency Contact Relationship _____

How did you hear about us _____

Driver's License Number _____

Driver's License State _____

Date of expiration of the license _____

CARE TEAM

Primary Care Physician _____

Pharmacy _____

Did someone refer you here? _____



INSURANCE INFORMATION

PRIMARY INSURANCE

Medical Insurance company name _____

Policy number _____ Group ID _____

Insured First Name _____ Insured Last Name _____

Insured DOB _____ Patients relationship to insurance holder _____

Insured address _____ Insured City _____

Insured State _____ Insured Zipcode _____

SECONDARY INSURANCE

Medical Insurance company name _____

Policy number _____ Group ID _____

Insured First Name _____ Insured Last Name _____

Insured DOB _____ Patients relationship to insurance holder _____

Insured address _____ Insured City _____

Insured State _____ Insured Zipcode _____

Is this a new insurance policy for your family? Yes No



GUARANTOR

Patients relationship to financially responsible person? _____

First Name _____ Last Name _____

DOB _____ Gender _____

Mobile Number _____ Address1 _____

Address2 _____ Zipcode _____

City _____ State _____



Ages & Stages Questionnaires®

2 Month Questionnaire

1 month 0 days through 2 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby:
 Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



2 Month Questionnaire

1 month 0 days
through 2 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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When you speak to your baby, does she make sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby smile when you talk to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she turn her head to the side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her back, does she kick her legs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

GROSS MOTOR TOTAL _____

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|------|
| 1. Is your baby's hand usually tightly closed when he is awake? (If your baby used to do this but no longer does, mark "yes.") | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby grasp your finger if you touch the palm of her hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you put a toy in his hand, does your baby hold it in his hand briefly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your baby touch her face with her hands? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___* |
| 6. Does your baby grab or scratch at her clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



FINE MOTOR TOTAL

*If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your baby look at objects that are 8–10 inches away? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you move around, does your baby follow you with his eyes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby smile at you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you smile at your baby, does she smile back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby watch his hands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	<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. Did your baby pass the newborn hearing screening test? If no, explain: YES NO
2. Does your baby move both hands and both legs equally well? If no, explain: YES NO
3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: YES NO

OVERALL (continued)

4. Has your baby had any medical problems? If yes, explain:

 YES NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain:

 YES NO

6. Does anything about your baby worry you? If yes, explain:

 YES NO



2 Month ASQ-3 Information Summary

1 months 0 days through
2 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	22.77		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	41.84		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	30.16		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	24.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	33.71		●	●	●	●	●	●	○	○	○	○	○	○	○

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Passed newborn hearing screening test?
Comments: | Yes | NO | 4. Any medical problems?
Comments: | YES | No |
| 2. Moves both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about behavior?
Comments: | YES | No |
| 3. Family history of hearing impairment?
Comments: | YES | No | 6. 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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

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

If the baby'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						



Ages & Stages Questionnaires®

4 Month Questionnaire

3 months 0 days through 4 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____ Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to baby: Parent Guardian Teacher Child care provider Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



4 Month Questionnaire

3 months 0 days
through 4 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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. After you have been out of sight, does your baby smile or get excited when he sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby stop crying when she hears a voice other than yours?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby laugh?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby make sounds when looking at toys or people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her tummy, does she hold her head straight up, looking around? (She can rest on her arms while doing this.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR*(continued)*

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 5. When you hold him in a sitting position, does your baby hold his head steady? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



GROSS MOTOR TOTAL —

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. When you put a toy in her hand, does your baby wave it about, at least briefly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your baby grab or scratch at his clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. When you hold your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



FINE MOTOR TOTAL —

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. When you put a toy in her hand, does your baby look at it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. When you put a toy in his hand, does your baby put the toy in his mouth? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

PROBLEM SOLVING *(continued)*

6. When you dangle a toy above your baby while she is lying on her back, does your baby wave her arms toward the toy?



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

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

1. Does your baby watch his hands?



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

2. When your baby has her hands together, does she play with her fingers?

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

3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?

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

4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?

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

5. Before you smile or talk to your baby, does he smile when he sees you nearby?

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

6. When in front of a large mirror, does your baby smile or coo at herself?



<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. Does your baby use both hands and both legs equally well? If no, explain:

YES NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:

YES NO

OVERALL (continued)

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: YES NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: YES NO

5. Do you have concerns about your baby's vision? If yes, explain: YES NO

6. Has your baby had any medical problems in the last several months? If yes, explain: YES NO

7. Do you have any concerns about your baby's behavior? If yes, explain: YES NO

8. Does anything about your baby worry you? If yes, explain: YES NO



4 Month ASQ-3 Information Summary

3 months 0 days through
4 months 30 days

Baby's name: _____ Date ASQ completed: _____
 Baby'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	34.60		●	●	●	●	●	●	●	●	●	○	○	○	○
Gross Motor	38.41		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	29.62		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	34.98		●	●	●	●	●	●	●	●	○	○	○	○	○
Personal-Social	33.16		●	●	●	●	●	●	●	○	○	○	○	○	○

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. 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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
 If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
 If the baby'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						



Ages & Stages Questionnaires®

6 Month Questionnaire

5 months 0 days through 6 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____ Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to baby: Parent Guardian Teacher Child care provider Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #:	Age at administration in months and days:
Program ID #:	If premature, adjusted age in months and days:
Program name:	



6 Month Questionnaire

5 months 0 days
through 6 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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				COMMUNICATION TOTAL ___

GROSS MOTOR





	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you put your baby on the floor, does she lean on her hands while sitting? <i>(If she already sits up straight without leaning on her hands, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|---|-----------------------|-----------------------|-----|
| 5. If you hold both hands just to balance your baby, does he support his own weight while standing? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| 6. Does your baby get into a crawling position by getting up on her hands and knees? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| | GROSS MOTOR TOTAL | | | ___ |




FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|---|-----------------------|-----------------------|-----|
| 1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby reach for or grasp a toy using both hands at once? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? (If he already picks up a small object the size of a pea, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| 4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| 5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? (If he already picks up the crumb or Cheerio, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| 6. Does your baby pick up a small toy with only one hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| | FINE MOTOR TOTAL | | | ___ |





PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. When a toy is in front of your baby, does she reach for it with both hands? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When your baby is on his back, does he turn his head to look for a toy when he drops it? (If he already picks it up, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When your baby is on her back, does she try to get a toy she has dropped if she can see it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

PROBLEM SOLVING *(continued)*

		YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby pass a toy back and forth from one hand to the other?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby play by banging a toy up and down on the floor or table?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PROBLEM SOLVING TOTAL					—

PERSONAL-SOCIAL

		YES	SOMETIMES	NOT YET	
1. When in front of a large mirror, does your baby smile or coo at herself?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby act differently toward strangers than he does with you and other familiar people? <i>(Reactions to strangers may include staring, frowning, withdrawing, or crying.)</i>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. While lying on her back, does your baby play by grabbing her foot?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When in front of a large mirror, does your baby reach out to pat the mirror?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. While your baby is on his back, does he put his foot in his mouth?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby try to get a toy that is out of reach? <i>(She may roll, pivot on her tummy, or crawl to get it.)</i>		<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. Does your baby use both hands and both legs equally well? If no, explain:

 YES NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:

 YES NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

 YES NO

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

 YES NO

5. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

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

YES

NO

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

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO



6 Month ASQ-3 Information Summary

5 months 0 days through
6 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	29.65		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	22.25		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	25.14		●	●	●	●	●	○	○	○	○	○	○	○	○
Problem Solving	27.72		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	25.34		●	●	●	●	●	○	○	○	○	○	○	○	○

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. 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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

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

If the baby'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						



Ages & Stages Questionnaires®

8 Month Questionnaire

7 months 0 days through 8 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____ Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to baby: Parent Guardian Teacher Child care provider

Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #:	Age at administration in months and days:
Program ID #:	If premature, adjusted age in months and days:
Program name:	



8 Month Questionnaire

7 months 0 days
through 8 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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION





	YES	SOMETIMES	NOT YET	
1. If you call to your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby respond to the tone of your voice and stop his activity at least briefly when you say "no-no" to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
COMMUNICATION TOTAL				___

GROSS MOTOR





	YES	SOMETIMES	NOT YET	
1. When you put your baby on the floor, does she lean on her hands while sitting? (If she already sits up straight without leaning on her hands, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)



	YES	SOMETIMES	NOT YET	
3. Does your baby get into a crawling position by getting up on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. If you hold both hands just to balance your baby, does he support his own weight while standing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. When sitting on the floor, does your baby sit up straight for several minutes without using her hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—*
				
6. When you stand your baby next to furniture or the crib rail, does he hold on without leaning his chest against the furniture for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
GROSS MOTOR TOTAL				—
<i>*If Gross Motor item 5 is marked "yes" or "sometimes," mark Gross Motor item 1 "yes."</i>				

FINE MOTOR






	YES	SOMETIMES	NOT YET	
1. Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? (If she already picks up a small object, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your baby try to pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion, even if she isn't able to pick it up? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				

FINE MOTOR




(continued)

	YES	SOMETIMES	NOT YET	
5. Does your baby successfully pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion? (If he already picks up a crumb or Cheerio, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Does your baby pick up a small toy with the tips of her thumb and fingers? (You should see a space between the toy and her palm.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	FINE MOTOR TOTAL			—
	<i>*If Fine Motor Item 6 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."</i>			

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a toy and put it in his mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby play by banging a toy up and down on the floor or table?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. Does your baby pass a toy back and forth from one hand to the other?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. When holding a toy in his hand, does your baby bang it against another toy on the table?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	PROBLEM SOLVING TOTAL			—

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	___
1. When lying on her back, does your baby play by grabbing her foot? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When in front of a large mirror, does your baby reach out to pat the mirror? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby try to get a toy that is out of reach? (He may roll, pivot on his tummy, or crawl to get it.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. While your baby is on her back, does she put her foot in her mouth? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby drink water, juice, or formula from a cup while you hold it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby feed himself a cracker or a cookie?	<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. Does your baby use both hands and both legs equally well? If no, explain: YES NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: YES NO

OVERALL (continued)

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

 YES NO

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

 YES NO

5. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

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

 YES NO

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

 YES NO

8. Does anything about your baby worry you? If yes, explain:

 YES NO



8 Month ASQ-3 Information Summary

7 months 0 days through
8 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	33.06		●	●	●	●	●	●	●	●	○	○	○	○	○
Gross Motor	30.61		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	40.15		●	●	●	●	●	●	●	●	●	○	○	○	○
Problem Solving	36.17		●	●	●	●	●	●	●	●	○	○	○	○	○
Personal-Social	35.84		●	●	●	●	●	●	●	●	○	○	○	○	○

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. 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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

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

If the baby'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						



Ages & Stages Questionnaires®

9 Month Questionnaire

9 months 0 days through 9 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby: Parent Guardian Teacher Child care provider

Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



9 Month Questionnaire

9 months 0 days
through 9 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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION



	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				COMMUNICATION TOTAL —

GROSS MOTOR






	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

GROSS MOTOR

(continued)




		YES	SOMETIMES	NOT YET	
3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby walk beside furniture while holding on with only one hand?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
GROSS MOTOR TOTAL					—

FINE MOTOR


		YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby successfully pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
FINE MOTOR TOTAL					—

*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. When holding a toy in his hand, does your baby bang it against another toy on the table? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
			PROBLEM SOLVING TOTAL	—

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby drink water, juice, or formula from a cup while you hold it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby feed himself a cracker or a cookie?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	<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. Does your baby use both hands and both legs equally well? If no, explain: YES NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: YES NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: YES NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: YES NO

5. Do you have concerns about your baby's vision? If yes, explain: YES NO

6. Has your baby had any medical problems in the last several months? If yes, explain: YES NO

OVERALL (continued)

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

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO



9 Month ASQ-3 Information Summary

9 months 0 days through
9 months 30 days

Baby's name: _____ Date ASQ completed: _____
 Baby'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	13.97		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	17.82		●	●	●	●	○	○	○	○	○	○	○	○	○
Fine Motor	31.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	28.72		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	18.91		●	●	●	●	○	○	○	○	○	○	○	○	○

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. 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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

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

If the baby'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						



Ages & Stages Questionnaires®

10 Month Questionnaire 9 months 0 days through 10 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____ Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to baby: Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



10 Month Questionnaire

9 months 0 days
through 10 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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION



	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				COMMUNICATION TOTAL ___

GROSS MOTOR

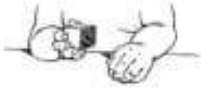




	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

GROSS MOTOR

(continued)




	YES	SOMETIMES	NOT YET	
3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
GROSS MOTOR TOTAL				—

FINE MOTOR


	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby successfully pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
FINE MOTOR TOTAL				—

*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. When holding a toy in his hand, does your baby bang it against another toy on the table?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PROBLEM SOLVING TOTAL				—

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby drink water, juice, or formula from a cup while you hold it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby feed himself a cracker or a cookie?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	<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. Does your baby use both hands and both legs equally well? If no, explain: YES NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: YES NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: YES NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: YES NO

5. Do you have concerns about your baby's vision? If yes, explain: YES NO

6. Has your baby had any medical problems in the last several months? If yes, explain: YES NO

OVERALL (continued)

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

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO



10 Month ASQ-3 Information Summary

9 months 0 days through
10 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	22.87		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	30.07		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	37.97		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	32.51		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	27.25		●	●	●	●	●	●	○	○	○	○	○	○	○

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. 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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

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

If the baby'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						



Ages & Stages Questionnaires®

12 Month Questionnaire

11 months 0 days through 12 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby: Parent Guardian Teacher Child care provider

Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



12 Month Questionnaire

11 months 0 days
through 12 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 baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "yes" if she knows one object.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When your baby wants something, does he tell you by pointing to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
			COMMUNICATION TOTAL	—



GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—







GROSS MOTOR

(continued)

	YES	SOMETIMES	NOT YET	
4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Does your baby stand up in the middle of the floor by himself and take several steps forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	GROSS MOTOR TOTAL			
				—

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? (The string may be attached to a toy.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? She may rest her arm or hand on the table while doing it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your baby 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"/>	—
				
6. Does your baby help turn the pages of a book? (You may lift a page for him to grasp.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	FINE MOTOR TOTAL			
				—

*If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|----|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? (If she already lets go of the toy into a bowl or box, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby drop two small toys, one after the other, 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"/> | —* |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby 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"/> | — |

**PROBLEM SOLVING TOTAL**

*If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? (If he already lets go of the toy into your hand, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby play with a doll or stuffed animal by hugging it? | <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. Does your baby use both hands and both legs equally well? If no, explain:

 YES NO

2. Does your baby play with sounds or seem to make words? If no, explain:

 YES NO

3. When your baby is standing, are her feet flat on the surface most of the time?
If no, explain:

 YES NO

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain:

 YES NO

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

 YES NO

OVERALL (continued)

6. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

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

 YES NO

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

 YES NO

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

 YES NO



12 Month ASQ-3 Information Summary

11 months 0 days through
12 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	15.64		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	21.49		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	34.50		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	27.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	21.73		●	●	●	●	●	○	○	○	○	○	○	○	○

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 6. Concerns about vision?
Comments: | YES | No |
| 2. Plays with sounds or seems to make words?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Concerns about not making sounds?
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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

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

If the baby'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						



Ages & Stages Questionnaires®

14 Month Questionnaire

13 months 0 days through 14 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby: Parent Guardian Teacher Child care provider

Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

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 baby.
- Make sure your baby 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 baby more than one time. If possible, try the activities when your baby is cooperative. If your baby can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby wants something, does she tell you by pointing to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby shake his head when he means "no" or "yes"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby point to, pat, or try to pick up pictures in a book?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby say four or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When you ask her to, does your baby 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"/>	___
	COMMUNICATION TOTAL			___




GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				

GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
3. Does your baby stand up in the middle of the floor by himself and take several steps forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your baby climb onto furniture or other large objects, such as large climbing blocks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby 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"/>	—
6. Does your baby move around by walking, rather than by crawling on his hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
GROSS MOTOR TOTAL				—

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby 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 baby 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"/>	—
4. Does your baby 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"/>	—
5. Does your baby 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 baby stack three small blocks or toys on top of each other by herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
FINE MOTOR TOTAL				—

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|----|
| 1. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although he may not let go of it? (If he already lets go of the toy into a bowl or box, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your baby drop two small toys, one after the other, into a container like a bowl or box? (You may show her how to do it.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —* |
| 3. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? (If he already scribbles on his own, mark "yes" for this item.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Can your baby 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"/> | — |
| 5. Does your baby drop several small toys, one after another, into a container like a bowl or box? (You may show her how to do it.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. After you have shown your baby how, does he try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



PROBLEM SOLVING TOTAL —

**If Problem Solving Item 2 is marked "yes" or "sometimes," mark Problem Solving Item 1 as "yes."*

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your baby roll or throw a ball back to you so that you can return it to him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your baby play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your baby feed herself with a spoon, even though she may spill some food? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby help undress himself by taking off clothes like socks, hat, shoes, or mittens? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby get your attention or try to show you something by pulling on your hand or clothes? | <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. Does your baby use both hands and both legs equally well? If no, explain:

 YES NO

2. Does your baby play with sounds or seem to make words? If no, explain:

 YES NO

3. When your baby is standing, are her feet flat on the surface most of the time?
If no, explain:

 YES NO

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain:

 YES NO

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

 YES NO

OVERALL (continued)

6. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

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

 YES NO

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

 YES NO

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

 YES NO



14 Month ASQ-3 Information Summary

13 months 0 days through
14 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	17.40		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	25.80		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	23.06		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	22.56		●	●	●	●	○	○	○	○	○	○	○	○	○
Personal-Social	23.18		●	●	●	●	○	○	○	○	○	○	○	○	○

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

- | | | | |
|--|---------------|--|---------------|
| 1. Uses both hands and both legs equally well?
Comments: | Yes NO | 6. Concerns about vision?
Comments: | YES No |
| 2. Plays with sounds or seems to make words?
Comments: | Yes NO | 7. Any medical problems?
Comments: | YES No |
| 3. Feet are flat on the surface most of the time?
Comments: | Yes NO | 8. Concerns about behavior?
Comments: | YES No |
| 4. Concerns about not making sounds?
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 baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.

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

If the baby'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						



Ages & Stages Questionnaires®

16 Month Questionnaire

15 months 0 days through 16 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____ Child's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to child: Parent Guardian Teacher Child care provider Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



16 Month Questionnaire

15 months 0 days
through 16 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child 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? <i>(You may lift a page for her to grasp.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child throw a small ball with a forward arm motion? <i>(If he simply drops the ball, mark "not yet" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child stack a small block or toy on top of another one? <i>(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)</i>	<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? <i>(He may turn more than one page at a time.)</i>	<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? <i>(If she already scribbles on her own, mark "yes" for this item.)</i>	<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? <i>(You may show him how to do it.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|----|
| 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?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —* |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| PROBLEM SOLVING TOTAL | | | | — |
| <i>*If Problem Solving Item 5 is marked "yes," mark Problem Solving Item 1 as "yes."</i> | | | | |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child feed himself with a spoon, even though he may spill some food? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child help undress herself by taking off clothes like socks, hat, shoes, or mittens? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. While looking at himself in the mirror, does your child offer a toy to his own image? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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? | <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		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	37.91		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	31.98		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	30.51		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	26.43		●	●	●	●	●	○	○	○	○	○	○	○	○

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						



Ages & Stages Questionnaires®

18 Month Questionnaire

17 months 0 days through 18 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____ Child's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to child: Parent Guardian Teacher Child care provider Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



18 Month Questionnaire

17 months 0 days
through 18 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. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. 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"/>	___
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. 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"/>	___
5. Without your showing him, does your child point to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. 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 TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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"/>	—
2. Does your child move around by walking, rather than by crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. 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"/>	—
5. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				GROSS MOTOR TOTAL





FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. 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"/>	—
2. 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"/>	—
3. 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"/>	—
4. Does your child stack three small blocks or toys on top of each other by himself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. 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"/>	—
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				FINE MOTOR TOTAL



PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. 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"/> | — |
| 2. 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | |  |
| 3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | |  |
| 6. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

PROBLEM SOLVING TOTAL

*If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. While looking at herself in the mirror, does your child offer a toy to her own image? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child drink from a cup or glass, putting it down again with little spilling? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair? | <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

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

OVERALL *(continued)*

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

 YES NO

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



18 Month ASQ-3 Information Summary

17 months 0 days through
18 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	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	○	○	○	○	○	○	○	○

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						



Ages & Stages Questionnaires®

20 Month Questionnaire 19 months 0 days through 20 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____ Child's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to child: Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #:	Age at administration in months and days:
Program ID #:	If premature, adjusted age in months and days:
Program name:	



20 Month Questionnaire

19 months 0 days
through 20 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child 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 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"/>	___
2. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Without your showing him, does your child point to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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 name at least one picture?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Without your giving him clues by pointing or using gestures, can your child carry out at least three 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"/> d. "Find your coat." <input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand." <input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book."				
6. 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 TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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"/>	—
2. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Does your child walk either up or down at least two steps by himself? He may also hold onto the railing or wall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	GROSS MOTOR TOTAL			—

FINE MOTOR

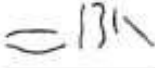
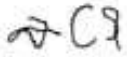

	YES	SOMETIMES	NOT YET	
1. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your child stack three small blocks or toys on top of each other by herself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. 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"/>	—
4. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child stack six small blocks or toys on top of each other by himself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

FINE MOTOR

(continued)

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 6. 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| FINE MOTOR TOTAL | | | | ___ |

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| Count as "yes"  | | | | |
| Count as "not yet"  | | | | |
| 3. If you do any of the following gestures, does your child copy at least one of them? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <input type="radio"/> a. Open and close your mouth. <input type="radio"/> c. Pull on your earlobe. | | | | |
| <input type="radio"/> b. Blink your eyes. <input type="radio"/> d. Pat your cheek. | | | | |
| 4. If you give your child a bottle, spoon, or pencil upside down, does she turn it right side up so that she can use it properly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. 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 at least two blocks side by side? (You can also use spools of thread, small boxes, or other toys.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
|  | | | | |
| 6. If your child wants something he cannot reach, does he 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)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| PROBLEM SOLVING TOTAL | | | | ___ |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your child feed herself with a spoon, even though she may spill some food? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your child drink from a cup or glass, putting it down again with little spilling? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

PERSONAL-SOCIAL *(continued)*

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-------------------------|
| 5. 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child eat with a fork? | <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

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

OVERALL (continued)

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

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



20 Month ASQ-3 Information Summary

19 months 0 days through
20 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	20.50		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	39.89		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	36.05		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	28.84		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	33.36		●	●	●	●	●	●	●	○	○	○	○	○	○

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						



Ages & Stages Questionnaires®

22 Month Questionnaire 21 months 0 days through 22 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____ Child's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to child: Parent Guardian Teacher Child care provider

Grandparent or other relative Foster parent Other: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____



22 Month Questionnaire

21 months 0 days
through 22 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child 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. 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Without your giving him clues by pointing or using gestures, can your child carry out at least three 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"/> d. "Find your coat."
<input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand."
<input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book." | | | | |
| 3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child say 15 or more words in addition to "Mama" and "Dada"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child correctly use at least two words like "me," "I," "mine," and "you"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. 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 TOTAL: ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your child walk down stairs if you hold onto one of his hands? He may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
				GROSS MOTOR TOTAL —

*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child stack six small blocks or toys on top of each other by himself? (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"/>	—

FINE MOTOR (continued)

	YES	SOMETIMES	NOT YET	
3. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. 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"/>	—
5. Does your child flip switches off and on?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				FINE MOTOR TOTAL



PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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 at least two blocks side by side? (You can also use spools of thread, small boxes, or other toys.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child pretend objects are something else? For example, does your child hold a cup to his ear, pretending it is a telephone? Does he put a box on his head, pretending it is a hat? Does he use a block or small toy to stir food?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. 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 her how.) (You can use a soda-pop bottle or a baby bottle.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. If you give your child a bottle, spoon, or pencil upside down, does he turn it right side up so that he can use it properly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				PROBLEM SOLVING TOTAL



PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PERSONAL-SOCIAL *(continued)*

	YES	SOMETIMES	NOT YET	
2. If you do any of the following gestures, does your child copy at least one of them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/> a. Open and close your mouth.				
<input type="radio"/> b. Blink your eyes.				
<input type="radio"/> c. Pull on your earlobe.				
<input type="radio"/> d. Pat your cheek.				
3. Does your child eat with a fork?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child drink from a cup or glass, putting it down again with little spilling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?	<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

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

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

OVERALL (continued)

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 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

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



22 Month ASQ-3 Information Summary

21 months 0 days through
22 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	13.04		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	27.75		●	●	●	●	●	●	○	○	○	○	○	○	○
Fine Motor	29.61		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.30		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	30.07		●	●	●	●	●	●	○	○	○	○	○	○	○

- 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						



Ages & Stages Questionnaires®

24 Month Questionnaire 23 months 0 days through 25 months 15 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



24 Month Questionnaire

23 months 0 days
through 25 months 15 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child 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 point 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 three 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"/> d. "Find your coat."
<input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand."
<input type="radio"/> c. "Bring me a towel." <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 name 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)

	YES	SOMETIMES	NOT YET	
6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
COMMUNICATION TOTAL				___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
GROSS MOTOR TOTAL				___

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

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child turn the pages of a book by herself? (She may turn more than one page at a time.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child flip switches off and on?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				FINE MOTOR TOTAL —



PROBLEM SOLVING

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

1. Does your child drink from a cup or glass, putting it down again with little spilling?
2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?
3. Does your child eat with a fork?
4. 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?
5. 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?
6. 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"/>	___
<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

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						



Ages & Stages Questionnaires®

27 Month Questionnaire 25 months 16 days through 28 months 15 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



27 Month Questionnaire

25 months 16 days
through 28 months 15 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child 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.

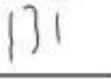
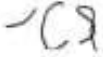



COMMUNICATION

	YES	SOMETIMES	NOT YET	___
1. Without your giving him clues by pointing or using gestures, can your child carry out at least three 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"/> d. "Find your coat." <input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand." <input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book."				
2. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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. Mark "sometimes" if she correctly points to at least three different body parts.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your child make sentences that are three or four words long? Please give an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				
6. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
COMMUNICATION TOTAL				___

GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child run fairly well, stopping herself without bumping into things or falling?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child jump with both feet leaving the floor at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child jump forward at least 3 inches with both feet leaving the ground at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. 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.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—*
GROSS MOTOR TOTAL					—
<i>*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."</i>					

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|---|-----------------------|-----------------------|---|
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child flip switches off and on? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | Count as "yes"
 | | | |
| | Count as "not yet"
 | | | |
| 4. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 6. After your child watches you draw a line from one side of the paper to the other side, ask her 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | Count as "yes"
 | | | |
| | Count as "not yet"
 | | | |

FINE MOTOR TOTAL —

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child pretend objects are something else? For example, does your child hold a cup to his ear, pretending it is a telephone? Does he put a box on her head, pretending it is a hat? Does he use a block or small toy to stir food? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child put things away where they belong? For example, does she know her toys belong on the toy shelf, her blanket goes on her bed, and dishes go in the kitchen? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. When looking in the mirror, ask "Where is _____?" (Use your child's name.) Does your child point to his image in the mirror? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. 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)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

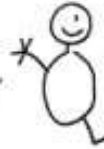
PROBLEM SOLVING *(continued)*

5. 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

6. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:



PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

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.
2. Does your child eat with a fork?
3. 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?
4. 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?
5. 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."
6. Does your child put on a coat, jacket, or shirt by himself?

YES SOMETIMES NOT YET

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

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 concerns about your child's vision? If yes, explain:

 YES NO

OVERALL (continued)

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

 YES NO

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



27 Month ASQ-3 Information Summary

25 months 16 days through
28 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	24.02		●	●	●	●	●	○	○	○	○	○	○	○	○
Gross Motor	28.01		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	18.42		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	27.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	25.31		●	●	●	●	●	○	○	○	○	○	○	○	○

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						



Ages & Stages Questionnaires®

30 Month Questionnaire 28 months 16 days through 31 months 15 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



30 Month Questionnaire

28 months 16 days
through 31 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:

COMMUNICATION

- | | YES | SOMETIMES | NOT YET | ___ |
|---|-----------------------|-----------------------|-----------------------|-----|
| 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 <i>name</i> at least one picture? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Without your giving him clues by pointing or using gestures, can your child carry out at least three 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"/> d. "Find your coat."
<input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand."
<input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book." | | | | |
| 3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child make sentences that are three or four words long? Please give an example: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <div style="border: 1px solid black; border-radius: 15px; height: 40px; width: 100%;"></div> | | | | |
| 5. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. 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," or "crying")? You may ask, "What is the dog (or boy) doing?" | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

COMMUNICATION TOTAL ___






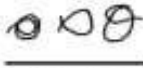
GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. 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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—*
				
6. Does your child stand on one foot for about 1 second without holding onto anything?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				

GROSS MOTOR TOTAL

*If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."

FINE MOTOR

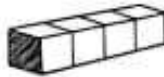
	YES	SOMETIMES	NOT YET	
1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div>			
3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. After your child watches you draw a line from one side of the paper to the other side, ask her 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div>			
5. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div>			
6. Does your child turn pages in a book, one page at a time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	FINE MOTOR TOTAL —			

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When looking in the mirror, ask, "Where is _____?" (Use your child's name.) Does your child point to her image in the mirror?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. If your child wants something he cannot reach, does he 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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING (continued)

3. 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 _____

4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:



5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same 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 your child draws a "picture," even a simple scribble, does she tell you what she drew? (You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

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.
2. Does your child use a spoon to feed himself with little spilling?
3. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?
4. Does your child put on a coat, jacket, or shirt by himself?
5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?
6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?

YES SOMETIMES NOT YET _____

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

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 toddlers 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

OVERALL (continued)

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

 YES NO

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



30 Month ASQ-3 Information Summary

28 months 16 days through
31 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	33.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.14		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	19.25		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	27.08		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	32.01		●	●	●	●	●	●	●	○	○	○	○	○	○

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 toddlers 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 toddlers?
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						



Ages & Stages Questionnaires®

33 Month Questionnaire 31 months 16 days through 34 months 15 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



33 Month Questionnaire

31 months 16 days
through 34 months 15 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:







- Try each activity with your child 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. When you ask your child to point to his nose, eyes, hair, feet, ears, and so forth, does he correctly point to at least seven body parts? (He can point to parts of himself, you, or a doll. Mark "sometimes" if he correctly points to at least three different body parts.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your child make sentences that are three or four words long? Please give an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				
3. Without giving your child help by pointing or using gestures, ask her to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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," or "crying"). You may ask, "What is the dog (or boy) doing?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When you ask, "What is your name?" does your child say his first name or nickname?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
COMMUNICATION TOTAL				___

GROSS MOTOR




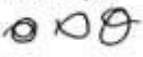


	YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your child stand on one foot for about 1 second without holding onto anything?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
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 should be scored as "not yet.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	GROSS MOTOR TOTAL			—

FINE MOTOR



	YES	SOMETIMES	NOT YET	
1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask her 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div>			

FINE MOTOR

(continued)

	YES	SOMETIMES	NOT YET	
2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. After your child watches you draw a line from one side of the paper to the other side, ask him 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	Count as "yes"  Count as "not yet" 			
4. After your child watches you draw a single circle, ask her to make a circle like yours. Do not let her trace your circle. Does your child copy you by drawing a circle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	Count as "yes"  Count as "not yet" 			
5. Does your child turn pages in a book, one page at a time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child try to cut paper with child-safe scissors? He 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
				FINE MOTOR TOTAL —

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When looking in the mirror, ask, "Where is ____?" (Use your child's name.) Does your child point to her image in the mirror?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. If your child wants something he cannot reach, does he 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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING (continued)

4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:



5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same 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 your child draws a "picture," even a simple scribble, does she tell you what she drew? (You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)

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 ___

PERSONAL-SOCIAL

1. Does your child use a spoon to feed herself with little spilling?
2. 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?
3. Does your child put on a coat, jacket, or shirt by herself?
4. After you put on loose-fitting pants around his feet, does your child pull them completely up to his waist?
5. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?
6. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?

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

2. Do you think your child talks like other toddlers 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 toddlers 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

OVERALL (continued)

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

 YES NO

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



33 Month ASQ-3 Information Summary

31 months 16 days through
34 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	25.36		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	34.80		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	12.28		●	●	●	○	○	○	○	○	○	○	○	○	○
Problem Solving	26.92		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	28.96		●	●	●	●	●	●	○	○	○	○	○	○	○

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 toddlers 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 toddlers?
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						



Ages & Stages Questionnaires®

36 Month Questionnaire

34 months 16 days through 38 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



36 Month Questionnaire

34 months 16 days
through 38 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:







- Try each activity with your child 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. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your child make sentences that are three or four words long? Please give an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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," or "crying")? You may ask, "What is the dog (or boy) doing?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When you ask, "What is your name?" does your child say both her first and last names?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
COMMUNICATION TOTAL				___

GROSS MOTOR


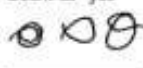




	YES	SOMETIMES	NOT YET	
1. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. Does your child stand on one foot for about 1 second without holding onto anything?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. 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 should be scored as "not yet.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	GROSS MOTOR TOTAL			—

FINE MOTOR


	YES	SOMETIMES	NOT YET	
1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask her 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div>			

FINE MOTOR

(continued)

	YES	SOMETIMES	NOT YET	
2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	Count as "yes"  Count as "not yet" 			
4. After your child watches you draw a line from one side of the paper to the other side, ask her 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	Count as "yes"  Count as "not yet" 			
5. Does your child try to cut paper with child-safe scissors? He 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	FINE MOTOR TOTAL —			

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. If your child wants something he cannot reach, does he 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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING (continued)

3. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:



4. When you say, "Say 'seven three,'" does your child repeat just the two numbers in the same 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.)
5. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it?
6. 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 for you to answer "yes" to this question.)



YES SOMETIMES NOT YET _____

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

1. Does your child use a spoon to feed herself with little spilling?
2. Does your child push a little wagon, stroller, or toy on wheels, steering it around objects and backing out of corners if he cannot turn?
3. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?
4. Does your child put on a coat, jacket, or shirt by himself?
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?
6. Does your child take turns by waiting while another child or adult takes a turn?

YES SOMETIMES NOT YET _____

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 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

OVERALL (continued)

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

 YES NO

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



36 Month ASQ-3 Information Summary

34 months 16 days through
38 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	30.99		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.99		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	18.07		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	30.29		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	35.33		●	●	●	●	●	●	●	●	○	○	○	○	○

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						



Ages & Stages Questionnaires®

42 Month Questionnaire 39 months 0 days through 44 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:
 Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

- Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



42 Month Questionnaire

39 months 0 days
through 44 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:






- Try each activity with your child 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. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. 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," or "crying")? You may ask, "What is the dog (or boy) doing?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. 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="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you ask, "What is your name?" does your child say both her first and last names?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Without your giving help by pointing or repeating directions, 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."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				COMMUNICATION TOTAL —

GROSS MOTOR

	YES	SOMETIMES	NOT YET	___
1. Does your child walk up stairs, using only one foot on each stair? <i>(The left foot is on one step, and the right foot is on the next.)</i> He may hold onto the railing or wall. <i>(You can look for this at a store, on a playground, or at home.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your child stand on one foot for about 1 second without holding onto anything?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
3. While standing, does your child throw a ball overhand by raising his arm to shoulder height and throwing the ball forward? <i>(Dropping the ball or throwing the ball underhand should be scored as "not yet.")</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. Does your child catch a large ball with both hands? <i>(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. 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"/>	___






			GROSS MOTOR TOTAL	___

FINE MOTOR



	YES	SOMETIMES	NOT YET	___
1. After your child watches you draw a single circle with a pencil, crayon, or pen, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
Count as "yes" 				
Count as "not yet" 				

FINE MOTOR

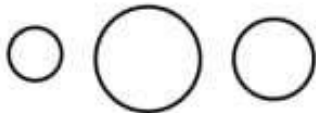
(continued)

	YES	SOMETIMES	NOT YET	
2. After your child watches you draw a line from one side of the paper to the other side, ask her 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	Count as "yes"  Count as "not yet" 			
3. Does your child try to cut paper with child-safe scissors? He 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. 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"/>	—
6. Using the shape at right to look at, does your child copy it onto a large piece of paper using a pencil, crayon, or pen, without tracing? (Your child's drawing should look like the design of the shape, except it may be different in size.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	FINE MOTOR TOTAL			—

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? (Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.") Please write your child's response here:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
	<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 470px; margin: 0 auto;"></div>			
2. When you say, "Say 'seven three,'" does your child repeat just the two numbers in the same 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				

PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 4. 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 for you to answer "yes" to this question.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
|  | | | | |
| 6. 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. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| PROBLEM SOLVING TOTAL | | | | — |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. 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="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child put on a coat, jacket, or shirt by herself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child take turns by waiting while another child or adult takes a turn? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child serve himself, 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child wash his hands using soap and water and dry off with a towel without help? | <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 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



42 Month ASQ-3 Information Summary

39 months 0 days through
44 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	27.06		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	36.27		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	19.82		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	28.11		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	31.12		●	●	●	●	●	●	○	○	○	○	○	○	○

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						



Ages & Stages Questionnaires®

48 Month Questionnaire 45 months 0 days through 50 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



48 Month Questionnaire

45 months 0 days
through 50 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child 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"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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:




<div style="border: 1px solid black; border-radius: 15px; height: 50px; margin: 5px 0;"></div>
"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:

<div style="border: 1px solid black; border-radius: 15px; height: 50px; margin: 5px 0;"></div> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

COMMUNICATION (continued)

	YES	SOMETIMES	NOT YET	
5. Without your giving help by pointing or repeating, does your child follow three directions that are <i>unrelated</i> 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."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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?"	<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"/>	—
				
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"/>	—
3. While standing, does your child throw a ball <i>overhand</i> 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"/>	—
				
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"/>	—
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"/>	—
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"/>	—
				
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"/>	—

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.)

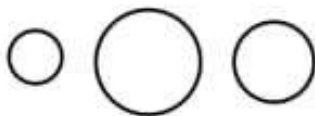


4. Does your child unbutton one or more buttons? (Your child may use his own clothing or a doll's clothing.)
5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?
6. Does your child color 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)*

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 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. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| PROBLEM SOLVING TOTAL | | | | ___ |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child tell you at least four of the following? Please mark the items your child knows. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <input type="radio"/> a. First name | | | | |
| <input type="radio"/> b. Age | | | | |
| <input type="radio"/> c. City she lives in | | | | |
| <input type="radio"/> d. Last name | | | | |
| <input type="radio"/> e. Boy or girl | | | | |
| <input type="radio"/> f. Telephone number | | | | |
| 3. Does your child wash his hands using soap and water and dry off with a towel without help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)? | <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 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		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○

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						



Ages & Stages Questionnaires®

54 Month Questionnaire

51 months 0 days through 56 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



54 Month Questionnaire

51 months 0 days
through 56 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:




- Try each activity with your child 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

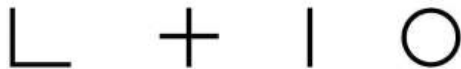
	YES	SOMETIMES	NOT YET	_____
1. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. 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," "Is there a toy to play with?" or "Are you coming, too?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. 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"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. Without giving your child help by pointing or repeating directions, does he follow three directions that are <i>unrelated</i> 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."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<div style="border: 1px solid black; border-radius: 15px; height: 50px; width: 100%;"></div>				
6. When talking about something that already happened, does your child use words that end in "-ed," such as "walked," "jumped," or "played"? Ask your child questions, such as "How did you get to the store?" ("We walked.") "What did you do at your friend's house?" ("We played.") Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<div style="border: 1px solid black; border-radius: 15px; height: 50px; width: 100%;"></div>				
				COMMUNICATION TOTAL _____

GROSS MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|--|
| 1. Does your child hop up and down on either the right foot or the left foot at least one time without losing her balance or falling? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. While standing, does your child throw a ball <i>overhand</i> 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. <i>(Dropping the ball or throwing the ball underhand should be scored as "not yet.")</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | |  |
| 3. Does your child jump forward a distance of 20 inches from a standing position, starting with her feet together? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child catch a large ball with both hands? <i>(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | |  |
| 5. 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? <i>(You may give your child two or three tries before you mark the answer.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | |  |
| 6. Does your child walk on his tiptoes for 15 feet (about the length of a large car)? <i>(You may show him how to do this.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

GROSS MOTOR TOTAL —

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. 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? <i>(Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | |  |
| 2. Does your child unbutton one or more buttons? Your child may use his own clothing or a doll's clothing. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? <i>(Your child should not go more than 1/4 inch outside the lines on most of the picture.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

FINE MOTOR

(continued)

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 4. Ask your child to trace on the line below with a pencil. Does your child trace on the line without going off the line more than two times? (Mark "sometimes" if your child goes off the line three times.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| _____ | | | | |
| 5. Ask your child to draw a picture of a person on a blank sheet of paper. You may ask your child, "Draw a picture of a girl or a boy." If your child draws a person with head, body, arms, and legs, mark "yes." If your child draws a person with only three parts (head, body, arms, or legs), mark "sometimes." If your child draws a person with two or fewer parts (head, body, arms, or legs), mark "not yet." Be sure to include the sheet of paper with your child's drawing with this questionnaire. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Draw a line across a piece of paper. Using child-safe scissors, does your child cut the 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



FINE MOTOR TOTAL _____

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. 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, sister, or an imaginary animal or figure. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. If you place five objects in front of your child, can she count them by saying, "One, two, three, four, five" in order? (Ask this question without providing help by pointing, gesturing, or naming.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. When asked, "Which circle is smallest?" does your child point to the smallest circle? (Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| | | | | |
| 5. Does your child count up to 15 without making mistakes? If so, mark "yes." If your child counts to 12 without making mistakes, mark "sometimes." | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 6. Does your child know the names of numbers? (Mark "yes" if he identifies the three numbers below. Mark "sometimes" if he identifies two numbers.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3 1 2 | | | | |
| | | | | PROBLEM SOLVING TOTAL |
| | | | | — |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Does your child wash her hands using soap and water and dry off with a towel without help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child brush his teeth by putting toothpaste on the toothbrush and brushing all of his teeth without help? (You may still need to check and rebrush your child's teeth.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. 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?) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child tell you at least four of the following? Please mark the items your child knows. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| <input type="radio"/> a. First name <input type="radio"/> d. Last name
<input type="radio"/> b. Age <input type="radio"/> e. Boy or girl
<input type="radio"/> c. City he lives in <input type="radio"/> f. Telephone number | | | | |
| 6. Does your child dress and undress herself, including buttoning medium-size buttons and zipping front zippers? | <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 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



54 Month ASQ-3 Information Summary

51 months 0 days through
56 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	31.85		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	35.18		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	17.32		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	28.12		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	32.33		●	●	●	●	●	●	●	○	○	○	○	○	○

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						



Ages & Stages Questionnaires®

60 Month Questionnaire

57 months 0 days through 66 months 0 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

Male Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



60 Month Questionnaire

57 months 0 days
through 66 months 0 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. Without your giving help by pointing or repeating directions, does your child follow three directions that are <i>unrelated</i> 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."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. When talking about something that already happened, does your child use words that end in "-ed," such as "walked," "jumped," or "played"? Ask your child questions, such as "How did you get to the store?" ("We walked.") "What did you do at your friend's house?" ("We played.") Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child use comparison words, such as "heavier," "stronger," or "shorter"? Ask your child questions, such as "A car is big, but a bus is ____" (bigger); "A cat is heavy, but a man is ____" (heavier); "A TV is small, but a book is ____" (smaller). Please write an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

COMMUNICATION (continued)

5. 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:

YES SOMETIMES NOT YET —
 —

"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:

YES SOMETIMES NOT YET —
 —

6. Does your child repeat the sentences shown below back to you, without any mistakes? (Read the sentences one at a time. You may repeat each sentence one time. Mark "yes" if your child repeats both sentences without mistakes or "sometimes" if your child repeats one sentence without mistakes.)

Jane hides her shoes for Maria to find.
 Al read the blue book under his bed.

 —

COMMUNICATION TOTAL —

GROSS MOTOR

1. 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.")



YES SOMETIMES NOT YET —
 —

2. 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.)



 —

3. 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.)




 —

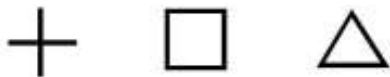
GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 4. Does your child walk on his tiptoes for 15 feet (about the length of a large car)? (You may show him how to do this.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child hop forward on one foot for a distance of 4–6 feet without putting down the other foot? (You may give him two tries on each foot. Mark "sometimes" if she can hop on one foot only.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child skip using alternating feet? (You may show him how to do this.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

GROSS MOTOR TOTAL —

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Ask your child to trace on the line below with a pencil. Does your child trace on the line without going off the line more than two times? (Mark "sometimes" if your child goes off the line three times.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| <hr style="width: 20%; margin: 10px auto;"/> | | | | |
| 2. Ask your child to draw a picture of a person on a blank sheet of paper. You may ask your child, "Draw a picture of a girl or a boy." If your child draws a person with head, body, arms, and legs, mark "yes." If your child draws a person with only three parts (head, body, arms, or legs), mark "sometimes." If your child draws a person with two or fewer parts (head, body, arms, or legs), mark "not yet." Be sure to include the sheet of paper with your child's drawing with this questionnaire. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Draw a line across a piece of paper. Using child-safe scissors, does your child cut the 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
|  | | | | |
| 4. Using the shapes below to look at, does your child copy the shapes in the space below without tracing? (Your child's drawings should look similar to the design of the shapes below, but they may be different in size. Mark "yes" if she copies all three shapes; mark "sometimes" if your child copies two shapes.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



(Space for child's shapes)

FINE MOTOR

(continued)

- | | YES | SOMETIMES | NOT YET | ___ |
|---|-----------------------|-----------------------|-----------------------|-----|
| 5. Using the letters below to look at, does your child copy the letters without tracing? Cover up all of the letters except the letter being copied. (Mark "yes" if your child copies four of the letters and you can read them. Mark "sometimes" if your child copies two or three letters and you can read them.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

V H T C A

(Space for child's letters)

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 6. Print your child's first name. Can your child copy the letters? The letters may be large, backward, or reversed. (Mark "sometimes" if your child copies about half of the letters.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
|--|-----------------------|-----------------------|-----------------------|-----|

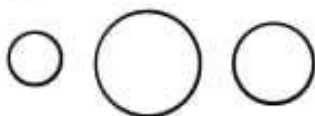
(Space for adult's printing)

(Space for child's printing)

FINE MOTOR TOTAL ___

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | ___ |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. When asked, "Which circle is smallest?" does your child point to the smallest circle? (Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 2. 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
|--|-----------------------|-----------------------|-----------------------|-----|

PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 3. Does your child count up to 15 without making mistakes? If so, mark "yes." If your child counts to 12 without making mistakes, mark "sometimes." | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child finish the following sentences using a word that means the opposite of the word that is italicized? For example: "A rock is <i>hard</i> , and a pillow is <i>soft</i> ." | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

Please write your child's responses below:

A cow is *big*, and a mouse is

Ice is *cold*, and fire is

We see stars at *night*, and we see the sun during the

When I throw the ball *up*, it comes

(Mark "yes" if he finishes three of four sentences correctly. Mark "sometimes" if he finishes two of four sentences correctly.)

- | | | | | |
|---|-----------------------|-----------------------|-----------------------|---|
| 5. Does your child know the names of numbers? (Mark "yes" if she identifies the three numbers below. Mark "sometimes" if she identifies two numbers.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3 1 2 | | | | |
| 6. Does your child name at least four letters in her name? Point to the letters and ask, "What letter is this?" (Point to the letters out of order.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Can your child serve himself, 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child wash her hands and face using soap and water and dry off with a towel without help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child tell you at least four of the following? Please mark the items your child knows. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| <input type="radio"/> a. First name | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> d. Last name |
| <input type="radio"/> b. Age | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> e. Boy or girl |
| <input type="radio"/> c. City he lives in | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> f. Telephone number |

PERSONAL-SOCIAL *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your child dress and undress himself, including buttoning medium-size buttons and zipping front zippers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child use the toilet by herself? (She goes to the bathroom, sits on the toilet, wipes, and flushes.) Mark "yes" even if she does this after you remind her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child usually take turns and share with other children?	<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

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

OVERALL (continued)

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

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



60 Month ASQ-3 Information Summary

57 months 0 days through
66 months 0 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	33.19		●	●	●	●	●	●	●	●	○	○	○	○	○
Gross Motor	31.28		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	26.54		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.99		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	39.07		●	●	●	●	●	●	●	●	○	○	○	○	○

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						

M-CHAT-R™

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.

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?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
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?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs)	Yes	No
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?)	Yes	No
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)	Yes	No
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)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?)	Yes	No
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)	Yes	No
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?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
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?)	Yes	No
13. Does your child walk?	Yes	No
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?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
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”?)	Yes	No
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”?)	Yes	No
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?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE , being swung or bounced on your knee)	Yes	No

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|---|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I always could <input type="checkbox"/> Not quite so much now <input type="checkbox"/> Definitely not so much now <input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I ever did <input type="checkbox"/> Rather less than I used to <input type="checkbox"/> Definitely less than I used to <input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> Not very often <input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> No, not at all <input type="checkbox"/> Hardly ever <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite a lot <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> No, not much <input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual <input type="checkbox"/> No, most of the time I have coped quite well <input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Only occasionally <input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Sometimes <input type="checkbox"/> Hardly ever <input type="checkbox"/> Never |
|---|---|

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME : _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

<p>10. If you checked off <i>any</i> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
---	--



Anxiety Screening (GAD 7)

NAME _____

DATE _____

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Becoming easily annoyed or Irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
TOTAL SCORE <i>(add your column scores)</i>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Scoring Add the results for question number one through seven to get a total score.

If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:

1. Drink any alcohol (more than a few sips)?
(Do not count sips of alcohol taken during family or religious events.) _____
2. Use any marijuana (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or synthetic marijuana? (like K2, Spice)? _____
3. Use anything else to get high? _____
(“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”)

For clinic use only: Did the patient answer “yes” to any questions in Part A?

No

Yes



Ask CAR question only, then stop

Ask all 6 CRAFFT questions

Part B

	No	Yes
1. Have you ever ridden in a <u>CAR</u> driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever use alcohol or drugs to <u>RELAX</u> , feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you ever use alcohol or drugs while you are by yourself, or <u>ALONE</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever <u>FORGET</u> things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your <u>FAMILY</u> or <u>FRIENDS</u> ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever gotten into <u>TROUBLE</u> while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

CONFIDENTIALITY NOTICE:

The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

© CHILDREN’S HOSPITAL BOSTON, 2009. ALL RIGHTS RESERVED.

Reproduced with permission from the Center for Adolescent Substance Abuse Research, CeASAR, Children’s Hospital Boston. (www.ceasar.org)

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

Copyright ©2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality



NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality





Vanderbilt Assessment Follow up – Parent Informant

Date: _____ Child's Name: _____ DOB: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors in the past _____ when rating his/her behaviors.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
2. Has difficulty playing or beginning quiet play activities	0	1	2	3
3. Fidgets with hands or feet or squirms in seat	0	1	2	3
4. Leaves seat when remaining seated is expected	0	1	2	3
5. Runs about or climbs too much when remaining seated is expected	0	1	2	3
6. Talks too much	0	1	2	3
7. Blurts out answers before questions have been completed	0	1	2	3
8. Has difficulty waiting his or her turn	0	1	2	3
9. Interrupts or intrudes on others' conversations and/or activities	0	1	2	3
10. Avoids, dislikes or does not want to start tasks that require ongoing mental effort	0	1	2	3
11. Has difficulty organizing tasks and activities	0	1	2	3
12. Has difficulty keeping attention to what needs to be done	0	1	2	3
13. Does not seem to listen when spoken to directly	0	1	2	3
14. Is easily distracted by noises or other stimuli	0	1	2	3
15. Is forgetful in daily activities	0	1	2	3
16. Loses things necessary for tasks or activities (toys, pencils, assignments or books)	0	1	2	3
17. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
18. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3

Performance	Somewhat of a Problem				
	Excellent	Above Average	Average	Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (teams)	1	2	3	4	5



Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite – explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon or evening – explain below				
Socially withdrawn – decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking – explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing – explain below				
Sees or hear things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1-18: _____

Average Performance Score for questions 19-26: _____

- 5589 Okeechobee Blvd. Suite 102 West Palm Beach, FL 33417 (561) 471-1144
- 12955 Palma West Dr. Suite 100, Loxahatchee, FL 33470 (561) 798-2468
- 8200 S. Jog Rd. Suite 101, Boynton Beach, FL 33472 (561) 509-5009

Screen for Child Anxiety Related Disorders (SCARED) Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: _____

Date: _____

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.	0	1	2
2. I get headaches when I am at school.	0	1	2
3. I don't like to be with people I don't know well.	0	1	2
4. I get scared if I sleep away from home.	0	1	2
5. I worry about other people liking me.	0	1	2
6. When I get frightened, I feel like passing out.	0	1	2
7. I am nervous.	0	1	2
8. I follow my mother or father wherever they go.	0	1	2
9. People tell me that I look nervous.	0	1	2
10. I feel nervous with people I don't know well.	0	1	2
11. I get stomachaches at school.	0	1	2
12. When I get frightened, I feel like I am going crazy.	0	1	2
13. I worry about sleeping alone.	0	1	2
14. I worry about being as good as other kids.	0	1	2
15. When I get frightened, I feel like things are not real.	0	1	2
16. I have nightmares about something bad happening to my parents.	0	1	2
17. I worry about going to school.	0	1	2
18. When I get frightened, my heart beats fast.	0	1	2
19. I get shaky.	0	1	2
20. I have nightmares about something bad happening to me.	0	1	2

Screen for Child Anxiety Related Disorders (SCARED)
Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.	0	1	2
22. When I get frightened, I sweat a lot.	0	1	2
23. I am a worrier.	0	1	2
24. I get really frightened for no reason at all.	0	1	2
25. I am afraid to be alone in the house.	0	1	2
26. It is hard for me to talk with people I don't know well.	0	1	2
27. When I get frightened, I feel like I am choking.	0	1	2
28. People tell me that I worry too much.	0	1	2
29. I don't like to be away from my family.	0	1	2
30. I am afraid of having anxiety (or panic) attacks.	0	1	2
31. I worry that something bad might happen to my parents.	0	1	2
32. I feel shy with people I don't know well.	0	1	2
33. I worry about what is going to happen in the future.	0	1	2
34. When I get frightened, I feel like throwing up.	0	1	2
35. I worry about how well I do things.	0	1	2
36. I am scared to go to school.	0	1	2
37. I worry about things that have already happened.	0	1	2
38. When I get frightened, I feel dizzy.	0	1	2
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	0	1	2
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	0	1	2
41. I am shy.	0	1	2

SCORING:

A total score of **≥ 25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.
 A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: _____

Date: _____

Directions:

Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	0	1	2
2. My child gets headaches when he/she is at school.	0	1	2
3. My child doesn't like to be with people he/she doesn't know well.	0	1	2
4. My child gets scared if he/she sleeps away from home.	0	1	2
5. My child worries about other people liking him/her.	0	1	2
6. When my child gets frightened, he/she feels like passing out.	0	1	2
7. My child is nervous.	0	1	2
8. My child follows me wherever I go.	0	1	2
9. People tell me that my child looks nervous.	0	1	2
10. My child feels nervous with people he/she doesn't know well.	0	1	2
11. My child gets stomachaches at school.	0	1	2
12. When my child gets frightened, he/she feels like he/she is going crazy.	0	1	2
13. My child worries about sleeping alone.	0	1	2
14. My child worries about being as good as other kids.	0	1	2
15. When he/she gets frightened, he/she feels like things are not real.	0	1	2
16. My child has nightmares about something bad happening to his/her parents.	0	1	2
17. My child worries about going to school.	0	1	2
18. When my child gets frightened, his/her heart beats fast.	0	1	2
19. He/she gets shaky.	0	1	2
20. My child has nightmares about something bad happening to him/her.	0	1	2

Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	0	1	2
22. When my child gets frightened, he/she sweats a lot.	0	1	2
23. My child is a worrier.	0	1	2
24. My child gets really frightened for no reason at all.	0	1	2
25. My child is afraid to be alone in the house.	0	1	2
26. It is hard for my child to talk with people he/she doesn't know well.	0	1	2
27. When my child gets frightened, he/she feels like he/she is choking.	0	1	2
28. People tell me that my child worries too much.	0	1	2
29. My child doesn't like to be away from his/her family.	0	1	2
30. My child is afraid of having anxiety (or panic) attacks.	0	1	2
31. My child worries that something bad might happen to his/her parents.	0	1	2
32. My child feels shy with people he/she doesn't know well.	0	1	2
33. My child worries about what is going to happen in the future.	0	1	2
34. When my child gets frightened, he/she feels like throwing up.	0	1	2
35. My child worries about how well he/she does things.	0	1	2
36. My child is scared to go to school.	0	1	2
37. My child worries about things that have already happened.	0	1	2
38. When my child gets frightened, he/she feels dizzy.	0	1	2
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	0	1	2
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	0	1	2
41. My child is shy.	0	1	2

SCORING:

A total score of ≥ 25 may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu



Name: _____

Today's Date: _____

ASTHMA CONTROL TEST™

Know your score.

The Asthma Control Test™ provides a numerical score to help you and your healthcare provider determine if your asthma symptoms are well controlled.

Take this test if you are 12 years or older. Share the score with your healthcare provider.

Step 1: Write the number of each answer in the score box provided.

Step 2: Add up each score box for the total.

Step 3: Take the completed test to your healthcare provider to talk about your score.

IF YOUR SCORE IS 19 OR LESS, Your asthma symptoms may not be as well controlled as they could be.

No matter what the score, bring this test to your healthcare provider to talk about the results.

NOTE: If your score is 15 or less, your asthma may be very poorly controlled. Please contact your healthcare provider right away. There may be more you and your healthcare provider could do to help control your asthma symptoms.

- | | | | | | SCORE |
|--|--------------------------|---------------------------|--------------------------|---------------------------|-------|
| 1. In the <u>past 4 weeks</u> , how much of the time did your <u>asthma</u> keep you from getting as much done at work, school or at home? | | | | | |
| All of the time [1] | Most of the time [2] | Some of the time [3] | A little of the time [4] | None of the time [5] | |
| 2. During the <u>past 4 weeks</u> , how often have you had shortness of breath? | | | | | |
| More than Once a day [1] | Once a day [2] | 3 to 6 times a week [3] | Once or twice a week [4] | Not at all [5] | |
| 3. During the <u>past 4 weeks</u> , how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning? | | | | | |
| 4 or more nights a week [1] | 2 to 3 nights a week [2] | Once a week [3] | Once or twice [4] | Not at all [5] | |
| 4. During the <u>past 4 weeks</u> , how often have you used your rescue inhaler or nebulizer medication (such as albuterol)? | | | | | |
| 3 or more times per day [1] | 1 to 2 times per day [2] | 2 or 3 times per week [3] | Once a week or less [4] | Not at all [5] | |
| 5. How would you rate your asthma control during the past 4 weeks? | | | | | |
| Not Controlled at All [1] | Poorly Controlled [2] | Somewhat Controlled [3] | Well Controlled [4] | Completely Controlled [5] | |

TOTAL:



Screening Checklist for Contraindications to Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH / /
month / day / year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the person to be vaccinated anxious about getting a shot today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____



FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4066.pdf
Item #P4066 (8/10/2023)



Scan for PDF

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Injectable Influenza Vaccination (IIV or RIV)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the "Note" below.

NOTE: For supporting documentation on the answers given below, go to the ACIP vaccine recommendation found at www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html.

1. Is the person to be vaccinated sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with a moderate or severe illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?

All vaccines, including influenza vaccines, contain various components that might cause allergic reactions, including anaphylaxis.

ACIP and CDC do not consider egg allergy of any severity to be a contraindication or precaution to egg-based influenza vaccines: people with any type of egg allergy may receive any influenza vaccine (egg-based or non-egg-based) that is otherwise appropriate for their age and health status.

Inactivated influenza vaccines provided in multidose vials contain thimerosal as a preservative. Most people who had sensitivity to thimerosal when it was used in contact lens solution do not have reactions to thimerosal when it is used in vaccines.

Check the package insert at www.immunize.org/official-guidance/fda/pkg-inserts for a list of the vaccine components (i.e., excipients and culture media) used in the production of the vaccine, or go to www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states.

For the 2024–2025 influenza season, no vaccine or packaging contains latex.

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?

Patients reporting a serious reaction to a previous dose of influenza vaccine should be asked to describe their symptoms. Immediate—presumably allergic—reactions are usually a contraindication to further vaccination against influenza. Do not give any egg-based IIV to a person who has experienced a serious systemic or anaphylactic reaction to a prior dose of any influenza vaccine (i.e., egg-based inactivated influenza vaccine [IIV], cell culture-based IIV [cIIV], recombinant influenza vaccine [RIV], or live attenuated influenza vaccine [LAIV]). For cIIV, history of a severe allergic reaction (e.g., anaphylaxis) to any cIIV or any component of cIIV is a contraindication to future use of cIIV. For RIV, history of a severe allergic reaction (e.g., anaphylaxis) to any RIV or any component of RIV is a contraindication to future use of RIV.

Fever, malaise, myalgia, and other systemic symptoms most often affect people who are first-time vaccinees. These local reactions are not a contraindication to future vaccination. These people can receive injectable vaccine without further evaluation.

A history of a severe allergic reaction to a previous dose of any egg-based IIV, LAIV, or RIV is a precaution to use of cIIV. A history of a severe allergic reaction to a previous dose of any egg-based IIV, cIIV, or LAIV is a precaution to use of RIV. Use of cIIV and RIV in such instances should occur in an inpatient or outpatient medical setting under supervision of a provider who can recognize and manage a severe allergic reaction; providers can also consider consulting with an allergist to help identify the vaccine component responsible for the reaction.

4. Has the person to be vaccinated ever had Guillain-Barré Syndrome?

People who are not at high risk for severe influenza complications and who are known to have developed Guillain-Barré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination should not be vaccinated. As an alternative, clinicians might consider using influenza antiviral chemoprophylaxis for these people. However, the benefits of influenza vaccination might outweigh the possible risks for certain people who have a history of GBS within 6 weeks after receipt of influenza vaccine and who are at higher risk for severe complications from influenza.

5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?

Fainting (syncope) or dizziness (presyncope) is not a contraindication or precaution to vaccination. However, for some people these can be a response to vaccination anxiety. People in adolescent and young adult age groups are more likely to experience syncope. CDC recommends that vaccine providers consider observing all patients for 15 minutes after vaccination. This is especially important for people with a pattern of injection-related syncope. For more information about vaccination-related syncope, see www.immunize.org/catg.d/p4260.pdf.

6. Is the person to be vaccinated anxious about getting a shot today?

Anxiety can lead to vaccine hesitancy or avoidance. Simple steps can help a patient's anxiety about vaccination. Visit Immunize.org's "Improving the Vaccination Experience" for clinical resources by going to www.immunize.org/clinical/vaccine-confidence/topic/improving-vaccine-experience/.

Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH / /
month day year

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine, (LAIV, FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to an ingredient of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (e.g., diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g., caused by sickle cell disease])?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated currently taking influenza antiviral medications, or have they taken any within the past 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin- or salicylate-containing medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the person to be vaccinated pregnant or could they become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the person to be vaccinated ever had Guillain-Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____



Information for Healthcare Professionals about the Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the "Note" below. In this document, IIV includes cIIV, unless otherwise noted.

NOTE: For supporting documentation on the answers given below, go to the ACIP vaccine recommendation found at www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html.

1. Is the person to be vaccinated sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with an acute febrile illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics. However, if nasal congestion might reduce delivery of the vaccine, delay LAIV (FluMist; AstraZeneca) or use injectable influenza vaccine.

2. Does the person to be vaccinated have an allergy to an ingredient of the influenza vaccine?

A history of an anaphylactic reaction such as wheezing, difficulty breathing, circulatory collapse or shock, or who required epinephrine or another emergency medical intervention after a previous dose of LAIV usually means no further doses of LAIV should be given. **Eggs:** ACIP and CDC do not consider egg allergy of any severity to be a contraindication or precaution to egg-based influenza vaccines: people with any type of egg allergy may receive any influenza vaccine (egg-based or non-egg-based) that is otherwise appropriate for their age and health status. **Other ingredients:** For a complete list of vaccine ingredients, including excipients and culture media used in the production of the vaccine, check the LAIV package insert at www.immunize.org/official-guidance/fda/pkg-inserts.

3. Has the person to be vaccinated ever had a serious reaction to any influenza vaccine in the past?

Patients reporting a serious reaction to a previous dose of any influenza vaccine (i.e., any egg-based inactivated influenza vaccine (IIV), cell-culture based (cIIV), recombinant influenza vaccine (RIV), or LAIV) should be asked to describe their symptoms. Immediate—presumably allergic—reactions are usually a contraindication to further vaccination with LAIV.

4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?

LAIV is only licensed and recommended for use in people age 2 through 49 years.

5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (e.g., diabetes)?

The safety of LAIV in people with any of these health conditions has not been established. These conditions, including asthma in people age 5 years and older, should be considered precautions for the use of LAIV.

6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you that the child had wheezing or asthma?

LAIV is not recommended for a child this age if their parent or guardian answers yes to this question or if the child has a history of asthma or recurrent wheezing. Instead, the child should be given the injectable vaccine (IIV4) appropriate for their age.

7. Does the person to be vaccinated have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g. caused by sickle-cell disease])?

People with these conditions should not be given LAIV. Instead, they should be given an IIV or RIV appropriate for their age.

8. Is the person to be vaccinated currently taking influenza antiviral medication, or have they taken any with the past 3 weeks?

Receipt of certain influenza antivirals could reduce LAIV vaccine effectiveness; therefore, providers should defer vaccination with LAIV in people who took zanamivir or oseltamivir within 48 hours, peramivir within 5 days, or baloxavir within 17 days. Patients should also be advised to avoid use of these antivirals for 14 days after vaccination, if feasible. Any IIV or RIV may be administered without regard to antiviral use.

9. Is the person to be vaccinated a child or teen age 6 months through 17 years who is receiving aspirin therapy or aspirin-containing therapy?

Because of the theoretical risk of Reye's syndrome, children age 6 months through 17 years on aspirin therapy should not be given LAIV. Instead they should be vaccinated with any IIV or RIV.

10. Is the person to be vaccinated pregnant or could they become pregnant within the next month?

Pregnant people or those planning to become pregnant within a month should not be given LAIV. All pregnant people should, however, be vaccinated with IIV or RIV. Pregnancy testing is not necessary before administering LAIV.

11. Has the person to be vaccinated ever had Guillain-Barré Syndrome?

People who are not at high risk for severe influenza complications and who are known to have developed GBS within 6 weeks after receiving a previous influenza vaccination should generally not be vaccinated. As an alternative, clinicians might consider using influenza antiviral chemoprophylaxis for these people. However, the benefits of influenza vaccination might outweigh the possible risks for certain people who have a history of GBS within 6 weeks after receipt of influenza vaccine and who are at higher risk for severe complications from influenza.

12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?

An IIV or RIV is preferred for people who anticipate close contact with a severely immunosuppressed person during periods in which the immunosuppressed person requires care in protective isolation (e.g., in a specialized patient-care area with a positive airflow relative to the corridor, high-efficiency particulate air filtration, and frequent air changes). Any IIV, RIV, or LAIV may be used in people who have close contact with people having lesser degrees of immunosuppression.

13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?

People who were previously given an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) should wait at least 28 days before receiving LAIV (30 days for yellow fever). LAIV can be given on the same days as other live vaccines. There is no reason to defer giving LAIV if people were vaccinated with an inactivated vaccine (including a COVID-19 vaccine), or if they have recently received blood or other antibody-containing blood products (e.g., immunoglobulin).



Asthma Control Test Caregiver

1. In the past 1 week, how much of the time did your child's asthma limit him or her from doing usual physical activities such as running, swimming, sports, walking uphill or upstairs and bicycling?

- All of the time Most of the time Some of the time A little of the time
 None of the time

2. During the past 1 week, how often has your child had breathing problems such as wheezing, coughing, or shortness of breath?

- 3 or more times per day 1 or 2 times per day 2 or 3 times during the week
 Once during the week Not at all

3. During the past 1 week, how often did your child's asthma symptoms (wheezing, coughing, shortness of breath) wake him or her up at night or earlier than usual in the morning?

- 4 or more nights 3 nights 2 nights 1 night Not at all

4. During the past 1 week, how often has your child used his or her rescue inhaler or nebulizer medication (such as Albuterol, Ventolin®, Proventil®, or Maxair®)?

- 3 or more times per day 1 or 2 times per day 2 or 3 times during the week
 Once during the week Not at all

5. How would you rate your child's asthma control during the past 1 week?

- Not Controlled at all Poorly Controlled Somewhat Controlled
 Well Controlled Completely Controlled



SEEK Safe Environment for Every Kid

Name: _____ Date: _____

Date of birth: _____ Relationship: _____

Would you like us to give you the phone number for Poison Control? Yes No

Do you need to get a smoke alarm for your home? Yes No

Does anyone smoke at home? Yes No

In the past 12 months, did you worry that your food would run out before you could buy more?

Yes No

In the past 12 months, did the food you bought just not last and you didn't have money to get more?

Yes No

Do you often feel your child is difficult to take care of? Yes No

Do you sometimes find you need to slap or hit your child? Yes No

Do you often feel under extreme stress? Yes No

Over the past 2 weeks, have you often felt down, depressed, or hopeless? Yes No

Over the past 2 weeks, have you felt little interest or pleasure in doing things? Yes No

Have you and a partner fought a lot? Yes No

Has a partner threatened, shoved, hit or kicked you or hurt you physically in any way?

Yes No

Have you had 4 or more drinks in one day? Yes No

Have you used an illegal drug or a prescription medication for nonmedical reasons?

Yes No

Are there other things you'd like help with today? Yes No

Please list other things you'd like help with today: _____



Notice of Privacy Practices

This Notice is provided to you pursuant to the privacy regulations enacted as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. This joint notice of privacy practices describes how your medical information may be used and disclosed and how you can get access to your information. This Notice applies to all your medical information created or maintained by the members of the Privia Health Affiliated Covered Entity / Organized Healthcare Arrangement (collectively referred to in this Notice as "Privia" and is further defined in Section B below). **Please review this notice carefully.**

A. OUR COMMITMENT TO YOUR PRIVACY

Privia is committed to maintaining the privacy of your health information. We are required by law to (i) maintain the privacy of your health information; (ii) provide you with this notice of our legal duties and privacy practices with respect to your health information; (iii) follow the terms of the notice of privacy practices currently in effect; and (iv) notify you if there is a breach of your health information. We must also provide you with the following important information: (a) how we may use and disclose your health information; (b) your privacy rights; and (c) our obligations concerning the use and disclosure of your health information.

This Notice of Privacy Practices is NOT an authorization; rather it describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes as permitted or required by law. It also describes your rights to access and control your Protected Health Information

"Protected Health Information" ("PHI") means information that identifies you individually; including demographic information, and information that relates to your past, present, or future physical or mental health condition and/or related health care services.

B. PERSONS/ENTITIES COVERED BY THIS NOTICE

Your provider is part of an Affiliated Covered Entity and/or Organized Health Care Arrangement (OHCA) by virtue of his or her affiliation with a member of the Privia Medical Group or Texas Health Care family, Health First Medical Group, Health First Privia Medical Group, Premier Medical Group, Privia Medical Group Tennessee and/or a Privia Quality Network (Privia Health's Clinically Integrated Networks and Accountable Care Organizations) (collectively these entities are referred to as "Privia"). For the purposes of complying with federal privacy and security requirements, the above-described entities have designated themselves as an ACE and/or OHCA. An OHCA is a clinically integrated care setting in which patients may receive care from multiple providers who share a common set of privacy practices. Privia providers have agreed to follow the terms of this Notice when providing services through Privia. Legally separate covered entities that are affiliated may designate themselves as a single covered entity or ACE for purposes of the HIPAA privacy rule. Although each care center is legally separate and responsible for its own acts, Privia coordinates privacy practices among the Privia care centers. Patient information is shared across the Privia ACE/OHCA for treatment, payment, and healthcare operations related to the ACE/OHCA. Your PHI can be shared across the ACE/OHCA for the purposes of your treatment, payment, and healthcare operations. When PHI is shared for healthcare operations, the person or organization using your PHI must have a relationship with you, unless your PHI is used for quality assurance, utilization review, and peer review purposes.

IMPORTANT: Privia may disclose your PHI to providers affiliated with the Privia ACE/OHCA and other independent medical professionals in order to provide patient treatment and for payment purposes and healthcare operations. Although providers affiliated with the Privia ACE/OHCA have agreed to follow this Notice and participate in the Privia privacy program, they are independent professionals and Privia expressly disclaims any responsibility or liability for their acts or omissions relating to your care or privacy/security rights.

C. CONTACT FOR QUESTIONS

For more information or questions about the privacy policies of the Privia ACE/OHCA, please contact:

Privacy Officer
950 N Glebe Rd, Suite 700
Arlington, VA 22203
(571) 317-0679
privacy@priviahealth.com

D. USE AND DISCLOSURE OF YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI)

1. Treatment. Privia may use or share your PHI to provide medical treatment or services for you and manage and coordinate your medical care. Privia may disclose your PHI to physicians and health care providers (including pharmacists), durable medical equipment (DME) vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that your medical providers have the necessary information to diagnose and provide treatment to you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may affect the healing process. Privia may also disclose your PHI to individuals who are directly involved in your care, including family members, friends or other care providers. If you participate in a virtual visit (telehealth), your information will be shared electronically via a secure transmission to facilitate the virtual visit.

2. Payment. Privia may use and disclose your PHI in order to bill for services provided and collect payment from health plans or other entities. For example, we may disclose PHI to your health insurance plan so it will pay for your services, determine your eligibility for coverage, or to obtain prior approval from the insurer to cover payment for treatment. Privia also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, including family members. Privia may also disclose your information to a collection agency to obtain overdue payment or to a regulatory agency or insurance company to determine whether the services we provided were medically necessary or appropriately billed.

3. Health Care Operations. Privia and its providers may use and disclose your PHI to run our businesses, improve your care, and contact you when necessary. For example: We may use or disclose your PHI: (1) to conduct quality or patient safety activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, and contacting your health care providers and you with information about treatment alternatives; (2) when conducting training programs or performing accreditation, licensing, or credentialing activities; (3) when conducting or arranging for medical review, legal services, and auditing functions; and (4) for our proper management and administration, including customer service, resolving complaints, strategic planning, etc. In addition, we may use or disclose de-identified information or a limited data set for certain healthcare operations purposes. We may also record your visit in order to facilitate the documentation of your care by your provider via a scribe or virtual scribe service.

4. Appointment Reminders, Check-In and Results. Privia may use and disclose your PHI to contact you and remind you of an appointment. Privia may use a sign-in sheet at the registration desk and call you by name in the waiting room when your provider is ready to see you. Privia may also use your PHI to contact you about test results. Privia may leave a message reminding you of an appointment or the results of certain tests, but will leave the minimum amount of information necessary to communicate this information.

5. Treatment Options and Health-Related Benefits and Services. Privia may use and disclose your PHI to inform you of treatment options or alternatives as well as certain health-related products, benefits or services that may be of interest to you. Privia may also use and disclose your PHI to provide you with information about payment for such products, benefits or services, including payment that might be available to you through your benefit plan. Privia may also use or disclose your PHI to offer information on other providers participating in a healthcare network in which Privia participates. In addition, Privia may use or disclose PHI to have communications sent to Privia's patients about certain government and government-sponsored programs including the Medicare Advantage and Medicare Part D Prescription Drug programs.

6. Disclosures to Family or Friends. Privia may disclose your PHI to individuals involved in your care or treatment or responsible for payment of your care or treatment. If you are incapacitated, we may disclose your PHI to the person named in your Durable Power of Attorney for Health Care or your personal representative (the individual authorized by law to make health-related decisions for you). In the event of a disaster, your PHI may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition.

7. Disclosures Required By Law. Privia will use and disclose your PHI when we are required to do so by federal, state or local law. For example, Privia may disclose PHI to comply with child and elder abuse reporting laws or to report certain diseases, injuries or deaths to state or federal agencies.

E. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. Public Health Reporting. Privia may disclose and may be required by law to disclose your PHI for certain public health purposes. For example, Privia may disclose your PHI to the Food and Drug Administration (FDA) regarding the quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; to report child abuse and/or neglect; to report reactions to medications or problems with health products; to provide notification of recalls of products; or report a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition. In addition, Privia may provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student if you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

2. Health Oversight Activities. Privia may disclose your PHI to a health oversight agency for investigations, inspections, audits, surveys, licensure and disciplinary actions, and in certain civil, administrative, and criminal procedures or actions, or other health oversight activities as authorized by law.

3. Lawsuits and Disputes. Privia may disclose your PHI in response to a court or administrative order, subpoena, request for discovery, or other legal processes. However, absent a court order, Privia will generally disclose your PHI if you have authorized the disclosure or efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

4. Law Enforcement. Privia may disclose your PHI if requested by a law enforcement official: (a) regarding a crime victim in certain situations, if we are unable to obtain the person's agreement; (b) about a death we believe resulted from criminal conduct; (c) regarding criminal conduct on our premises; (d) in response to a warrant, summons, court order, subpoena or similar legal process; (e) to identify/locate a suspect, material witness, fugitive or missing person; or (f) in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased Patients. Privia may disclose your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. In addition, we may disclose PHI necessary for funeral directors to fulfill their responsibilities.

6. Organ and Tissue Donation. Privia may disclose your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation or blood banks, as necessary to facilitate donation and transplantation if you are a donor.

7. Research. Privia may use and disclose your PHI to researchers for the purpose of conducting research with your written authorization or when the research has been approved by an Institutional Review Board and is in compliance with law governing research. In certain situations, the need for your individual consent may be waived by a Privacy Board.

8. Serious Threats to Health or Safety. Privia may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military, National Security, and other Specialized Government Functions: If you are in the military or involved in national security or intelligence, Privia may disclose your PHI to authorized officials. Privia also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct certain investigations.

10. Workers' Compensation. Privia will disclose only the PHI necessary for worker's compensation in compliance with worker's compensation laws. This information may be reported to your employer and/or your employer's representative in the case of an occupational injury or illness.

11. Inmates. If you are an inmate or in the custody of a law enforcement official, Privia may disclose your PHI to correctional institutions or law enforcement officials as necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the law enforcement officer or the correctional institution; and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Minors. If you are a minor (generally an individual under 18 years old), we may disclose your PHI to your parent or guardian unless otherwise prohibited by law.

F. YOUR PRIVACY RIGHTS REGARDING YOUR PHI

1. Inspection and Copies. You may request a copy of, or request to inspect, the PHI that is used to make decisions about you, including medical and billing records and laboratory and imaging reports. You have the right to obtain an electronic copy if it is readily producible by us in the form and format requested, or you may request that we provide a paper copy of your record. You may also request a summary of your record. We will provide your health information, to you or whomever you designate to receive it, usually within thirty (30) days of your request, or fifteen (15) days if your provider is in Texas. Privia may charge a reasonable cost-based fee to cover the costs of copying, mailing, labor and supplies associated with your request. Privia may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. There may be times that your provider, in his or her professional judgment, may not think it is in your best interest to have access to your medical record. Depending on the reason for the decision to deny a request, we may ask another licensed provider chosen by us to conduct a review of your request and its denial.

2. Confidential Communications. You may request in writing that we communicate with you in a specific way or send mail to a different address. For example, you may request that we contact you at home, rather than work or by mail. Privia will accommodate all reasonable requests. You do not need to give a reason for your request. We will comply with your request if we are reasonably able to do so.

3. Amendment. You may request a correction or amendment of your PHI if you believe it is incorrect or incomplete. You may make a written request for a correction or amendment for as long as your PHI is maintained by or for Privia. Requests must provide a reason or explanation that supports the request. Privia will deny your request if it is not in writing or if, in the provider's opinion, the information is: (a) accurate and complete; (b) not part of the PHI maintained by or for Privia; (c) not part of the PHI that you have the right to inspect and copy; or (d) not created by Privia, unless the individual or entity that created the information is not available to amend the information. Privia will notify you in writing within sixty (60) days if we cannot fulfill your request.

4. Accounting of Disclosures. You may request an accounting of certain disclosures that Privia has made of your PHI. This accounting will list the disclosures that we have made of your PHI but will not include disclosures made for the purposes of treatment, payment, health care operations, disclosures required by law, and certain other disclosures (such as any you asked us to make). Your request must be in writing and state the time period for which you want the accounting (not to exceed six (6) years prior to the date you make the request). Privia will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. Privia will notify you of the costs involved with any additional request and you may withdraw your request before you incur any costs.

5. Requests for Restrictions. You have the right to request that Privia not use or share your PHI for treatment, payment, or health care operations. We are not required to agree to your request, and we may say "no" if we believe it might affect your care. If you pay for a service or health care item out-of-pocket in full, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. In that case, we will approve your request unless a law specifically requires us to share that information.

6. Health Information Exchange Opt-Out: You have the right to opt-out of disclosure of your medical records to or via an electronic health information exchange ("HIE") (For example, Surescripts, Commonwell, CareQuality aka The Sequoia Project, ConnectVirginia and/or the Chesapeake Regional Information System for our Patients, Inc. ("CRISP")). However, information that is sent to or via an HIE prior to processing your opt-out may continue to be maintained by and be accessible through the HIE. You must opt out of disclosures to or via an HIE through each of your individual treating providers who may participate in any given HIE. See H. USING TECHNOLOGY TO IMPROVE HEALTHCARE below for more information regarding HIE.

7. Right to Receive a Notice of a Breach of Unsecured Medical Information. You have the right to receive prompt notice in writing of a breach of your PHI that may have compromised the privacy or security of your information.

8. Right to a Paper Copy of This Notice. You have the right to receive a paper copy of this notice at any time even if you have agreed to receive the notice electronically. You may also obtain a copy of this notice at our website -- priviahealth.com/HIPAA .

9. Right to File a Complaint. If you believe your rights have been violated, you may file a complaint with us or with the Secretary of the

Department of Health and Human Services ("HHS"), Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

G. ADDITIONAL INFORMATION

1. Patient Portal and Other Patient Electronic Correspondence. Privia may use and disclose your PHI through various secure patient portals that allow you to view, download and transmit certain medical and billing information and communicate with certain health care providers in a secure manner through the portal. For more information on the Privia patient portal, please visit our website at www.priviahealth.com/signin.html.

2. Your Contact Information: Home and Email Addresses/Phone Numbers. If you provide us with a home or email address, home/work/cell telephone number, or other contact information during any registration or administrative process we will assume that the information you provided us is accurate and that you consent to our use of this information to communicate with you about your treatment, payment for service and health care operations. You are responsible to notify us of any change of this information. Privia reserves the right to utilize third parties to update this information for our records as needed.

3. Email or Downloading PHI. If you email us medical or billing information from a private email address (such as a Yahoo, Gmail, etc. account), your information may not be secure in transmission. We therefore recommend you use your Privia patient portal to communicate with us regarding your care and/or billing issues. If you request that Privia email your PHI to a private email address, we will send it in an encrypted manner unless you request otherwise. Privia is not responsible for the privacy or security of your PHI if you request that we send it to you in an unsecured manner or download or post it on a dropbox, unencrypted USB drive, CD or other unsecure medium. In addition, Privia is not responsible if your PHI is redisclosed, damaged, altered or otherwise misused by an authorized recipient. In addition, if you share an email account with another person (for example, your spouse/partner/roommate) or you choose to store, print, email, or post your PHI, it may not be private or secure.

4. Sensitive Health Information. Federal and state laws provide special protection for certain types of health information, including psychotherapy notes, information about substance use disorders and treatment, mental health and AIDS/HIV or other communicable diseases, and may limit whether and how we may disclose information about you to others.

5. Substance Use Disorder Records and Information. The confidentiality of patient records maintained by federally assisted substance use disorder rehabilitation programs is protected by Federal law and regulations. Generally, such programs may not disclose any information that would identify an individual as having or being treated for a substance use disorder unless:

- a. the individual consents in writing;
- b. the disclosure is allowed by a court order;
- c. the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
- d. as otherwise permitted by law.

(Notwithstanding the preceding, we may disclose certain information that could identify you as having a substance use disorder pursuant to paragraph 6, below.) Violation of these laws and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not prevent any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

6. Consent to Disclose Sensitive Health and Substance Use Disorder Information. The Privia Authorization & Consent to Treat form you sign as part of the registration process includes your consent to the release of federally assisted substance use disorder information, information regarding treatment of communicable diseases and mental health information for the purposes specified in this notice. If you do not wish for this information to be disclosed, you must notify us in writing and we will determine if it is feasible for us to accept your request.

7. Incidental Disclosures. Despite our efforts to protect your privacy, your PHI may be overheard or seen by people not involved in your care. For example, other individuals at your provider's office could overhear a conversation about you or see you getting treatment. Such incidental disclosures are not a violation of HIPAA.

8. Business Associates.Your PHI may be disclosed to individuals or entities who provide services to or on behalf of Privia. Pursuant to HIPAA, Privia requires these companies sign business associate or confidentiality agreements before we disclose your PHI to them. However, Privia generally does not control the business, privacy, or security operations of our business associates.

9. Authorization for Other Uses and Disclosures.Privia will obtain your written authorization for uses and disclosures that are not identified by this notice or otherwise required or permitted by applicable law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. However, your revocation will not affect actions we have already taken; in other words, we are unable to take back any disclosures of PHI we have already made.

H. USING TECHNOLOGY TO IMPROVE HEALTHCARE Health Information Exchange (HIE) enables your healthcare providers to quickly and securely share your health information electronically among a network of healthcare providers, including physicians, hospitals, laboratories and pharmacies. Your health information is transmitted securely and only authorized healthcare providers with a valid reason may access your information.

How does HIE Help You?

Improved access to information will enable us to provide better care for our patients.

- **Improved Care** - Access to information about your health history and medical care gives your healthcare provider a more complete picture of your overall health. This can help your provider make better decisions about your care. The information may also prevent you from having repeat tests, saving you time, money and worry.
- **Emergency Treatment** - In an emergency, your providers may immediately check to see if you have allergies, health problems, test results, medications or previous concerns that may help them provide you with emergency care.
- **Helps to Protect Privacy and Information Security** -By sharing information electronically through a secure system, the risk that your paper or faxed records will be misused or misplaced is reduced.

How does HIE help protect your medical information and keep it secure?

Privia is committed to protecting the privacy and security of your health information, including the sharing and accessing of your information through HIE.

- Every HIE and its participants must protect your private medical information under HIPAA law, as well as applicable state laws and regulations.
- Information shared via HIE is encrypted, meaning it can be accessed only by authorized users. This prevents hackers from accessing your information.
- Every individual who can access your information must have their own user name and password and must receive training before they can access your information.
- The HIE records every time someone accesses your information. Upon request, the HIE can track who accessed your information and provide a report to the Privia Privacy Officer.

You have choices about participating in HIE.

Privia recognizes you have certain rights related to how we share your information. You have the following choices:

Choice 1: Say Yes. No further action needed.

If you agree to have your medical information shared through HIE and you have a current Authorization and Consent to Treat form on file, you do not need to do anything. By signing the form, you have granted us permission to share your health information to HIE.

Choice 2: Say No Thanks. Follow the Instructions on the HIE Opt-Out Form.

We recognize your right to choose not to participate in HIE, also referred to as opting-out. If you decide to opt-out of HIE, healthcare providers will not be able to access your health information through HIE. You should understand that providers may still request and receive your medical information from other providers using other methods permitted by law, such as fax, mail or other electronic communication.

If you want to opt-out of participating in HIE, please follow the appropriate procedure as outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly. You may download and print the form on your computer or ask for a copy at any Privia care center location. Please read the Opt-Out Request Form carefully and follow the instructions on the form to opt out of HIE.

Please note, your opt-out does not affect health information that was disclosed through HIE prior to the time that you opted out.

Choice 3: You can change your mind at any time.

You can consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt-out form described under Choice 2.

You can opt out of HIE today and change your mind later by submitting a *Privia HIE Reinstatement of Participation Form* or, in certain cases, by contacting the HIE directly. The reinstatement form is available to download and print on your computer or you may ask for a copy of the form at any Privia care center location. Please follow the instructions on the form to opt back in to HIE.

If you have any questions about HIE, you can email privacy@priviahealth.com. To opt-out of HIE, please email medicalrecords@priviahealth.com.

I. NO WAIVER. Under no circumstances will Privia require an individual to waive his or her rights under the HIPAA Privacy Rule or the HIPAA Breach Notification Rule as a condition for receiving treatment.

J. CONTACT/COMPLAINT INFORMATION. If you have any questions about this Notice or wish to file a privacy complaint, please contact:

Privacy Officer
950 N Glebe Rd, Suite 700
Arlington, VA 22203
(855) 541-9048 (toll free)
or email privacy@priviahealth.com

You can file a complaint directly with the **U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to:
200 Independence Avenue, S.W
Washington, D.C. 20201
calling 1-877-696-6775
or online at: www.hhs.gov/ocr/privacy/hipaa/complaints/

If your provider is licensed in Texas, you can also file a complaint with the **Texas Department of State Health Services Investigations:**
P.O. Box 141369
Austin, Texas 78714-1369.

signature _____

Date _____



Notice of Privacy Practices Acknowledgement

I acknowledge that Julie Tomberlin MD PA has made available to me a copy of the practice's Notice of Privacy Practices, which is at the front desk.
I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

DISCLAIMER: By typing your name below, you are signing this application electronically in agreement with the above policies and statements. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

signature _____ Date _____



Privia Preferred Communication and Contacts Policy

Preferred Communication *

- Home Telephone Written Communication
 Cell Phone Other
 Work Telephone

Cell Phone Number *

Cell Phone Options *

My Preferred Contacts: *

Medical Contact Permission *

Preferred Communication:

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name:

Date of Birth:

I prefer to be contacted in the following manner:

Home Telephone:

- OK to leave message with detailed information
 Leave message with call-back number only

Cell Phone:

- OK to leave message with detailed information
 Leave message with call-back number only

Work Telephone:

- OK to leave message with detailed information
 Leave message with call-back number only

Written Communication:

- Please send all of my mail to my home address on file
 Please send all mail to THIS address

Other:

Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below. **Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 -- Monday - Friday 8am - 6pm ET.

I want **NO ONE** to receive my personal health information

I want the following person(s) **TO BE ALLOWED** to access my Personal health information:

Please indicate the person(s) you prefer we share your information with below:

Name:

Telephone:

Relationship:

Name:

Telephone:

Relationship:

Name:

Telephone:

Relationship:

By providing your mobile number, you consent to receive text messages from Dr. Julie's Office, including:

- *Appointment reminders and confirmations
- *Health-related notifications and communication
- *Billing and payment alerts
- *Feedback or post-visit survey
- *Two-factor authentication (2FA) for patient portal security
- *Practice updates and alerts

Message frequency: Varies by appointment and account activity

Rates: Standard message/data rates may apply

Opt-out: Text "STOP" to unsubscribe

Support: Text "HELP" or call (682) 518-8111

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons not named on this form as needed for my care or treatment or to obtain payment for services provided.

Date Signed:

Signature :



Late Arrival, Cancellation and No Show Policy

In an effort to give everyone the full attention they deserve, we ask that our families help us by arriving ten minutes prior to their appointment time. This allows us to have all the check in and vitals completed so that you are ready to be seen by your scheduled appointment time. We have the following policies in place regarding late arrival, late cancellation, and missed appointments.

Late Arrival

If you arrive after your child's scheduled appointment time, we reserve the right to see him/her on a "work-in only" basis or to reschedule him/her to the next open appointment time. Extended wait times should be expected if your child is worked in.

NO SHOW

If your scheduled appointment is missed, you will be charged \$50 for missed sick or follow up appointments and \$100 for a missed well check or behavioral health appointment. Initial Behavioral Health appointments missed or late canceled will be a \$200 fee.

We will dismiss your family if there are 3 missed appointments for the family.

Well check and Behavioral Health appointment forms must be completed at least one day prior to your scheduled appointment. If they are not completed within the required time frame, your appointment will be canceled and a \$100 no show fee will apply.

New patients who miss their first scheduled appointment will not be eligible for establishment with our practice.

LATE CANCELLATIONS

An appointment that is canceled less than 24 hours prior to the scheduled appointment time will be charged a \$25 fee.

If you make a sick appointment for the same day and then decide to cancel it, we require notice within 1 hour of setting the appointment (i.e. you called at 9am, we would need to hear from you by 10 am in order to avoid a late cancellation fee).

Automated appointment reminders are a courtesy only and should not be relied upon for keeping your child's appointment

Patient's name:

DOB:

Date:

Signature :

WELL CHILD POLICY

The well child visit is an opportunity to discuss your child's growth and development and discuss important age-related safety and behavior topics. This visit also allows us to do a complete physical exam so we can identify medical problems that may not be readily apparent without a thorough physical exam. The purpose of your child's visit is what is called "preventative care" — looking for and discussing issues that may affect your child's growth, development, and general well-being so we can identify and prevent smaller issues from progressing into larger problems.

Things that are included in your child's well visit:

- Measurement of weight, height/length, head circumference (age 2 and under), blood pressure (age 3 and up)
- Complete head-to-toe physical exam done by your provider (doctor or nurse practitioner)
- Discussion with your provider about your child's growth and nutrition/diet
- Discussion with your provider about normal developmental milestones and your child's progression in achieving these
- Discussion with your provider about normal age-related development and safety topics
- Discussion of sports-related screening questions for student athletes

If needed, your child will receive immunizations (shots) at the well child visit. Please note that these are billed separately to your insurance company. As a courtesy, we verify insurance eligibility for these shots prior to your child's visit. We, however, have limited access to coverage and benefit information, and you are ultimately responsible for knowing your plan limitations. If the immunizations are not covered by insurance, you will receive a bill from our office.

In addition to the above, many of our visits include other screening or preventative care. These are billed separately to your insurance company and may or may not be covered under your insurance plan. Rest assured that our recommendations for these services are made because they are a part of the American Academy of Pediatrics' Bright Futures Guidelines. These guidelines are the gold standard of care in pediatrics and are important to identifying any issues EARLY before they become larger problems. Most, but not all, insurance companies pay for services recommended under these guidelines. The following are a list of some of the items that fall into this group:

- Hemoglobin blood test
- Vision screening
- Hearing screening
- Standardized developmental surveys (ASQ, MCHAT)
- Depression, Anxiety, ADHD, lead, and other standardized screening questionnaires

Please also note that well child care does not include care of other chronic medical conditions (asthma, ADHD, allergies, mental health issues) or acute illnesses (ear infections, strep throat, gastrointestinal illnesses, etc.) that occur at the same time as the well visit. If we evaluate and treat chronic or acute conditions during the course of the well visit, we are mandated by your insurance company to document and bill separately for those issues. As such, you may be required to pay a copay. Please know that this is required by the insurance companies and we are forced to comply with this policy, as failure to do so would constitute insurance fraud.

It is our office policy that all patients have an annual well child exam (more frequently for children under 4yo). Failure to comply with this policy may result in dismissal from our practice.

I acknowledge I have read and understand the above policy. I agree I am responsible for any and all charges deemed to be my responsibility by my insurance carrier. These include, but are not limited to, copays, deductibles, coinsurance, benefits, and any services not covered by my insurance carrier.

DATE:

Signature :

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network: or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee or Payment & Pre-Certification. In consideration Of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit"). I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my providers website and at priviahealth.com/hipaa-privacy-notice and that I may request a paper copy at my providers reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. agree to the terms Of my provider's Financial Policy, the sharing of my information via HIE, and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient:

Email:

Date:

Name and Relationship of Person Signing, if not Patient:

Signature :

***Note:** If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.



Newborn policy

At Julie Tomberlin MD PA, we are honored to care for your newborn and want to make the billing process as smooth as possible while insurance is being established.

If Your Baby Already Has Active Insurance:

- We will make every effort to verify your baby's insurance before the first visit.
- If verified as active, we will bill your insurance as usual.
- Charges will be applied according to your insurance plan, including any copays, deductibles, or coinsurance amounts.

If Your Baby Does Not Yet Show Active Insurance:

- This is common in the first few weeks after birth.
- We will still see your baby and collect:
 - A **\$50 payment** at the first visit.
 - A **credit card on file** for future charges.
- We will bill your insurance for all visits in case of auto newborn coverage. You will be responsible for any copays, deductibles, or coinsurance amounts according to your plan.

If claims are denied due to lack of coverage, they will be reprocessed once your baby is officially added and insurance shows as active for the baby.

At 30 Days:

- If your baby is still **not active on insurance**, any visits done in the first month will be considered **self-pay**.
- Charges will go on a **payment plan** using the credit card on file.
- Our team will contact you to explain the plan and answer any questions.

We are here to help you through this process and will work hard to ensure your baby receives excellent care from day one. If you have any questions about this policy, insurance, or your baby's care, please don't hesitate to reach out.

Contact Us:

682-518-8111

706 Hunters Row Ct, Mansfield, TX 76063

Thank you for trusting us with your baby's care!

Signature _____ Date _____



Beyfortus Waiver

Name of Parent/Guardian who is
assuming responsibility for this charge

Name and Date of Birth
of person receiving the vaccine

I hereby authorize and give permission to Julie Tomberlin MD PA (JTMD) to give Beyfortus, a monoclonal antibody to protect against RSV, to my child. The total amount billed to insurance will be approximately \$1,131.00. This early eligibility determination is not a guarantee of payment from insurance.

• **Important Notices re: Prior Authorization:**

o Some insurance plans, including Baylor Scott & White insurance, require a prior authorization process to be completed or coverage will be denied. It is your responsibility to verify whether or not prior authorization is required and that prior authorization has been completed prior to receiving the Beyfortus injection. Please note, Julie Tomberlin MD PA cannot start the prior authorization process until after your child's insurance is in active status.

o JTMD cannot request prior authorization until the newborn is active on his/her health insurance plan.

• **Important Notices re: Insurance Coverage:**

o JTMD cannot submit the Beyfortus charge until the newborn is active on his/her health insurance plan. It is the responsibility of the guarantor to add the newborn to the insurance policy as soon as possible, but no later than 30 days after the child's date of birth. If my child's insurance is not active, I understand that I will owe \$600 as a discounted rate for prompt pay prior to the injection being administered. Once your child has been added to the insurance plan, JTMD will submit the claim to the insurance and remit reimbursement, if appropriate.

o If my child's insurance company DENIES payment of the injection as a non-covered service or because my child's insurance was inactive on the date of service, I understand that I will be personally responsible for payment for this visit for this service. Should my child's insurance not cover the service at all, I understand that I will owe \$600 as a discounted rate for prompt pay (since we will be charging your card on the same date that we are billing you).

o Should my child's insurance apply any or all of this visit to the deductible or any other cost-sharing arrangement (deductible, copays, co-insurance, etc.), I understand that I will be responsible for whatever that amount is and that JTMD cannot change this amount, as this is determined by the insurance company and coverage with them.

o There are select insurance plans that only cover the Beyfortus injection when administered in a pharmacy (covered under formulary benefits--not medical plan benefits). We are unable to verify this information prior to administration of the injection, and it is your responsibility to verify coverage for this service.

By signing below, I agree that the credit card that was placed on file will be the one charged as needed. This credit card will be charged when Julie Tomberlin MD PA receives notice from my insurance that I have a financial responsibility for any or all of the cost of Beyfortus.

I understand that JTMD will charge either \$600 or whatever is assigned to patient responsibility on the Explanation of Benefits at the time that the claim response is received in the office. I understand that I will not receive a call ahead of time before this amount is charged to my credit card.

I UNDERSTAND THAT IF MY CHILD IS ELIGIBLE TO RECEIVE VFC VACCINE (my child has no insurance and is not eligible for Medicaid), I NEED TO NOTIFY THE OFFICE IMMEDIATELY UPON RECEIPT OF THIS FORM.

Parent/Guardian Signature

Date



Pediatric Behavioral Health Policy

Your child's health and success are very important to us. Our goal is to provide the best possible care for children with behavioral health conditions which includes ADHD, Anxiety and/or Depression.

Often children with these behavioral health conditions require specialty care by a child psychiatrist or behavioral health-developmental pediatrician. Some children can be diagnosed and followed here in our office by our providers.

Our office will work with you to help decide the best course of action for your child.

Due to certain medications that are used to treat these conditions, Dr. Tomberlin has established an office policy for those initial behavioral health appointments as well as for the follow up appointments that will be needed. They are as follows:

Initial Behavioral Health Appointment requirements

1. All school aged children will be required to have a Teacher Vanderbilt Evaluation form completed and returned before we can schedule an appointment. This is needed for the purpose of seeing how your child is doing in a classroom setting, getting the teachers input academically and behaviorally, as well as how your child interacts with others.
2. Once the teacher forms have been received and the Initial appointment is set, you, the parent, will receive an appointment link to complete forms for the visit. These forms will assess ADHD, Anxiety and Depression. Even if you do not feel that your child has one of these issues, all forms are required to be completed for the providers to do a full and complete assessment. (Depending on your child's age, there could be forms for them to complete as well so please make sure your child is available when opening the appointment link.)

Please be aware that these initial evaluation appointments are scheduled for 1 hour to review the scored assessments, provide a diagnosis and come up with a plan to help your child.

Due to the length of this 1st initial appointment, there will be a \$200.00 fee applied if the appointment is canceled less than 24 hours prior to the appointment or if you do not show up for your appointment. Late fees will be applied as well, so please be mindful when choosing your appointment date and time.

Initial _____ (for acknowledgement of fee)

Follow up visit for ADHD, Anxiety & Depression

1. Follow up visits are very important and are required for our providers to continue providing care for these issues. They will be monitoring your child's response to treatment, side effects, and help you assess their progress. If appointments are consistently missed, canceled or rescheduled, the provider will no longer be able to provide Behavioral Health services for your

child and you will need to seek assistance elsewhere. Refills will only be provided if the appointments are consistent AND the next follow up appointment has been scheduled.

2. We understand that life happens and appointments need to be changed, however, should this be a continuous and consistent problem, we will no longer be able to provide Behavioral Health services for you.
3. There is limited time available for these types of visits but we will make every attempt to schedule them at times that are convenient for you and your child. It is usually best to schedule your follow up appointments before leaving the office. We understand that you do not want your child missing school for this but it may be necessary. We will provide you with a school note for your child.
4. Refill prescriptions will be sent within 3 business days so please call at least 1 week before you are out of medication to ensure that your child will not run out.
5. **SUMMER BREAK FOLLOW UP APPTS** - Routine follow-up appointments are also required throughout the summer, regardless of whether your child is taking medication over summer break or not. These visits are essential to monitor her progress, assess overall well-being, and check vital signs such as blood pressure and weight. Regular follow-ups allow us to manage your child's care appropriately and ensure they are supported during this time. Keeping these appointments also helps them stay on track and be prepared for the upcoming school year.

Discontinuing Medication and/or Behavioral Health Management

1. If you and the provider decide that medication and/or BH management is no longer needed, one final follow-up appointment will be required. This allows for a thoughtful review and leaves the door open should you decide to restart treatment in the future. Without this final visit, we will be unable to continue managing her Behavioral Health care, and you will need to seek services through an outside provider.

Behavioral Health Policy Agreement

I have read Dr. Tomberlin's policy agreement in its entirety.

I understand that medication prescriptions and refills will be provided as per the policies outlined in this document.

I agree to make and keep follow up appointments as recommended by my child's provider.

Patient Name

DOB

Parent/Guardian Signature

Printed Name

Date

Signature of Patient (18 or older)

Printed Name

Date

Julie Tomberlin, MD

706 Hunters Row Court, Mansfield, TX 76063

682-518-8111



NURSE PRACTITIONER / ADVANCED PRACTICE NURSE CONSENT FOR TREATMENT

Julie Tomberlin MD PA has on staff advanced practice nurses (Nurse Practitioners) to assist in the delivery of pediatric medical care.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my child's healthcare needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see the doctor, subject to availability.

Patient Name _____ DOB _____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____ Date _____



Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Minor Consent Form



A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

Form fields for Child's Name, Date of Birth, Gender, Telephone, Email address, Address, City, State, Zip Code, County, Mother's Name.

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities
I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2. A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.
Parent, legal guardian, or managing conservator:
Printed Name Signature Date

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request.

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. DO NOT fax to ImmTrac2. Retain this form in your client's record.



Initial History Questionnaire		NAME	
Form Completed By _____	Date _____	Birth Date _____	Age _____ M F _____

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date	Health Problems

Who is living in the child's home? _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not living in the home? _____

Birth History

Birth Weight _____ Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy? [] YES [] NO Explain _____

During pregnancy, did mother: Use drugs or medications [] YES [] NO Drink Alcohol [] YES [] NO Smoke [] YES [] NO

What _____ When _____

Was the delivery [] Vaginal? [] Cesarean? If cesarean, why? _____

Did your baby have any problems right after birth? [] YES [] NO Explain _____

Was initial feeding [] Breast? [] Bottle?

Did your baby go home with mother from the hospital? [] YES [] NO Explain _____

General

Do you consider your child to be in good health? [] YES [] NO Explain _____

Does your child have any serious illness or medical conditions? [] YES [] NO Explain _____

Has your child had serious injuries or accidents? [] YES [] NO Explain _____

Has your child had any surgery? [] YES [] NO Explain _____

Has your child ever been hospitalized? [] YES [] NO Explain _____

Is your child allergic to any medicines or drugs? [] YES [] NO Explain _____

Development

Are you concerned about your child's physical development? [] YES [] NO Explain _____

Are you concerned about your child's mental or emotional development? Are you concerned about your child's attention span? [] YES [] NO Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____



Preventive Medical Visit Patient Information

Dear Patient,

You are seeing your provider for a preventive medical visit. This is a comprehensive, preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures. Insurance carriers may or may not provide coverage for screening laboratory and diagnostic studies; rules are carrier specific. Preventive medical visits are usually exempt from copayments; however, you should always verify your patient responsibility obligations with your insurance provider.

However, if an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform key components of a problem-oriented evaluation and management service, then a separate office visit code may be charged. The use of this additional code will require, a co-payment, coinsurance or deductible if one is charged by your insurance plan.

If you have any questions, we advise you to contact your insurance carrier directly to discuss your coverage for these services.

Sincerely,

Julie Tomberlin, M.D., P.A.

I certify that I have read and understand the differences between preventive and problem-oriented visits, and agree to pay the associated copay should the nature of my visit change.

→ **Printed Name:** _____

→ **Signature:** _____ **Date:** _____

(To be signed by parent or legal guardian if patient is a minor under the age of 18, or a mentally incompetent patient.)

Patient's Name: _____

Today's Date: _____

Childhood Asthma Control Test for children 4 to 11 years.

This test will provide a score that may help the doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to the first four questions (1 to 4). If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining three questions (5 to 7) on your own and without letting your child's response influence your answers. There are no right or wrong answers.

Step 2 Write the number of each answer in the score box provided.

Step 3 Add up each score box for the total.





Step 4 Take the test to the doctor to talk about your child's total score.

19
or less





If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. Bring this test to the doctor to talk about the results.

Have your child complete these questions.





1. How is your asthma today?

 0 Very bad	 1 Bad	 2 Good	 3 Very good
---	--	---	--





2. How much of a problem is your asthma when you run, exercise or play sports?

 0 It's a big problem, I can't do what I want to do.	 1 It's a problem and I don't like it.	 2 It's a little problem but it's okay.	 3 It's not a problem.
---	---	--	---

3. Do you cough because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.
--	---	---	--

4. Do you wake up during the night because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.
--	---	---	--

Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
------------------------	----------------------	-----------------------	------------------------	------------------------	----------------------

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
------------------------	----------------------	-----------------------	------------------------	------------------------	----------------------

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
------------------------	----------------------	-----------------------	------------------------	------------------------	----------------------

SCORE

TOTAL

Refusal of Recommended Immunizations

Child's Name _____ ID# _____ DOB _____

Parent's / Guardian's Name _____

My child's pediatrician or other health care provider, _____, has advised me that my child (named above) should receive each vaccine or immunization checked below:

Recommended today, <i>which prevents these serious complications:</i>	Today I refused: <i>Initials of Parent or Guardian</i>
<input type="checkbox"/> COVID-19 vaccine <i>Pneumonia, respiratory failure, blood clots, bleeding disorder, injury to liver, heart or kidney, multi-system inflammatory syndrome, post-COVID syndrome, death</i>	
<input type="checkbox"/> Diphtheria, tetanus, acellular pertussis (DTaP or Tdap) vaccine <i>Tetanus – broken bones, breathing difficulty, death; Diphtheria – swelling of the heart muscle, heart failure, coma, paralysis, death; Pertussis(whooping cough) – pneumonia, death</i>	
<input type="checkbox"/> Haemophilus influenzae type B (Hib) vaccine <i>Meningitis, intellectual disability, closing of the throat, pneumonia, death</i>	
<input type="checkbox"/> Hepatitis A (HepA) vaccine <i>Liver failure, joint pain, kidney, pancreatic and blood disorders, death</i>	
<input type="checkbox"/> Hepatitis B (HepB) vaccine <i>Chronic liver infection, liver failure, liver cancer, death</i>	
<input type="checkbox"/> Human papillomavirus (HPV) vaccine <i>Cervical, vaginal, vulvar, penile, anal, mouth and throat cancers</i>	
<input type="checkbox"/> Influenza (flu) vaccine <i>Pneumonia, bronchitis, sinus infections, ear infections, death</i>	
<input type="checkbox"/> Measles, mumps, and rubella (MMR) vaccine <i>Measles - brain swelling, pneumonia, death; Mumps - meningitis, brain swelling, swelling of testicles or ovaries, deafness, death; Rubella – miscarriage, stillbirth, premature delivery, birth defects</i>	
<input type="checkbox"/> Meningococcal (circle: MenACWY / MenB / MenABCWY) vaccine <i>Meningitis, infection of the bloodstream, blindness, deafness, loss of limbs, death</i>	
<input type="checkbox"/> Pneumococcal (PCV) vaccine <i>Blood infection, meningitis, death</i>	
<input type="checkbox"/> Poliovirus (IPV) vaccine (inactivated) <i>Paralysis, death</i>	
<input type="checkbox"/> Respiratory syncytial virus (RSV) immunization <i>Bronchiolitis, pneumonia, lung failure, death</i>	
<input type="checkbox"/> Rotavirus (RV) vaccine <i>Severe diarrhea, dehydration, death</i>	
<input type="checkbox"/> Varicella Chickenpox (VAR) vaccine <i>Infected blisters, bleeding disorders, brain swelling, pneumonia, death</i>	
<input type="checkbox"/> Others (please list) _____	

I have been given a Vaccine Information Statement from the Centers for Disease Control and Prevention that explains each immunization and the disease(s) it prevents. I have discussed the recommendation and my refusal with my child's pediatrician or other healthcare provider. They have answered all of my questions about the recommended immunizations. I know I can find more information at <https://www.cdc.gov/vaccines/parents/FAQs.html>.

I understand the following:

- The checked immunization(s) are recommended by my child's pediatrician or healthcare provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention.
- The benefits and risks of the recommended immunization(s) checked.
- If my child does not receive the immunization(s) according to the standard, evidence-based schedule, the consequences may include:
 - Contracting the illness the immunization is designed to prevent, which could lead to serious complications as listed in the table.
 - Transmitting the disease to others (including those too young to be vaccinated or those with immune problems), possibly requiring my child to stay out of child care or school and requiring someone to miss work to stay home with my child during disease outbreaks.
- Some immunization-preventable diseases are common in other countries. My unvaccinated child could get one of these diseases while traveling or from someone who traveled to another country.

Today, I refused the recommended immunization(s) for my child by initialing the box(es) in the column titled "Today I refused."

I agree to tell all health care professionals in all settings which immunization(s) my child has not received and if my child is under immunized, as my child may need to be

If you change your mind at any time, speak with your child's pediatrician or other health care provider. You can always accept immunization(s) for your child in the future.

I acknowledge that I have read this document in its entirety and understand it.

Parent / Guardian Signature: _____ Date: _____

Pediatrician / Other Health Care Provider: _____ Date: _____



Integrative Medicine form

Name _____

DOB _____

Main Concern for child _____

What are your goals for this consult _____

When did this problem start for your child _____

How does it affect his/her daily life (at home and school): _____

What evaluation (if any) has been done for these concerns _____

What treatments (if any) have been tried? Did they help or no? Were there any side effects?

MEDICAL HISTORY:

Was your child born full term? Any complications with pregnancy or at birth?

Has your child had any major illnesses? _____

Does your child have any chronic illnesses? _____

Has your child had any ER visits or hospitalizations? Yes No

If yes, please explain _____

Has your child had any surgeries? _____

Does your child have any allergies to medications or foods? _____

Does your child have seasonal allergies? _____

SOCIAL HISTORY:

Who does the child live with? _____

Does the child have a regular routine? _____

Is the home generally stable and safe? _____

Are there stressors at home? Yes No

If so, what are they and how do they affect your child? _____

Who watches the child when he/she is not in school (summer, school breaks, illness)?

SCHOOL HISTORY:

What grade is your child in? _____

What school does he/she go to? Has the child changed schools? _____

How is he/she progressing academically? _____

Does your child get in trouble frequently at school? _____

Does he/she seem to enjoy school? _____

NUTRITION HISTORY:

24 hour recall of dietary intake:

Please list all foods and drinks your child consumed in the previous 24 hours. Include meals, snacks, beverages and condiments. Please include the food item, how it was prepared (baked, fried, etc) and the amount eaten (cup, tbs, ounces, etc)

Is this a typical day? Yes No

Why? _____

why not? _____

How many servings of fruit does your child eat/drink each day? _____

How many servings of vegetables does your child consume each day? _____

Does your child eat meat? Yes No

What other proteins does he/she eat? Yes No

How many times does your child have fast food on an average week? _____

Which junk foods does your child consume regularly? _____

How much water does your child drink daily? _____

How many sweet drinks does your child drink daily? _____

What kind? _____

Does your child eat breakfast? Yes No

What is a typical breakfast and what time is it eaten? _____

Does your child snack after dinner? Yes No

If so, on what and at what time? _____

SLEEP HISTORY:

In general, do you feel like your child is a good sleeper? Yes No

What time does your child go to bed? _____

How long does it take him/her to fall asleep? _____

Does he/she wake in the night? Yes No

Does he/she snore? Yes No

What time does your child wake up? _____

Does he/she arouse easily? Yes No

Seem tired in the morning? Yes No

Does your child complain of being tired in the day? Yes No

ACTIVITY HISTORY:

In general, is your child active or more sedentary? _____

Does your child participate in sports? Yes No

If so, approximately how many hours per week and during what "seasons"? _____

What does your child do for physical activity on a regular basis? _____

How much time is spent on this activity on an average day? _____

What type of screen times does your child engage in? _____

Approximately how many hours per day on a school day? on a weekend or non-school day?

EMOTIONAL HEALTH:

On a scale of 1-10 (with 1 being very poor, probably needs to be hospitalized and 10 being extraordinarily good, never seems down or stressed), how would you rate your child's general emotional state of being? _____

Does your child seem stressed out? Yes No

If so, do you know what causes the stress? _____

Does your child have any coping skills to deal with stress or other negative emotions? Yes No

If so, what seems to work? _____

Do you feel stressed? Yes No

How do you manage your stress? _____

Vitamins and Supplements:

What vitamins and/or supplements does your child take? _____

Please list brand, name of active ingredients and dosages, as well as how often it is taken

INTEGRATIVE MODALITIES:

Lastly, please check any of the following integrative modalities that you are not comfortable trying for your child:

- vitamins
- supplements
- botanicals (plant based medicines)
- meditation
- yoga
- biofeedback
- traditional Chinese medicine
- Ayurvedic medicine
- cognitive behavior therapy
- nutritional/dietary modifications
- hypnotherapy (clinical hypnosis)
- relaxation therapy
- music therapy
- pet/animal therapy
- guided imagery



Pediatrics New Patient Checklist

It is crucial when choosing a pediatric practice for your children that you have given serious consideration to the fit between the practice philosophies and your own. Excellent care happens when the physicians and office staff are aligned with your family priorities and philosophies regarding medical care. Only then can shared decision making be based on mutual respect.

Please read the following checklist carefully to be sure Julie Tomberlin MD Pediatrics is the appropriate medical home for your children. We look forward to meeting you and forming a mutually rewarding relationship.

Well Checks:

We require your child to be seen at our office for all well checks. Our schedule of well checks is as follows:

- newborn
- 2 weeks
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- 2.5 years
- 3 years

After age three, we will see your child yearly for a wellness examination.

Chronic Illnesses:

We require regular visits for managing chronic conditions like asthma, anxiety, ADHD, or eczema. Once the problem is under good control, appointments are required every 3-6 months for best management (depending on what problem it is). For example: The National Asthma Education and Prevention Program's expert panel recommends visits to a clinician about every six months for patients whose asthma is under control and more often for patients whose asthma is uncontrolled or have severe persistent asthma.

Vaccines:

Julie Tomberlin MD Pediatrics firmly believes in the effectiveness of vaccines to prevent serious illnesses and save lives. We also firmly believe in the safety of vaccines. All physicians and staff provide vaccines on schedule to our own children. Our office follows the vaccine schedule outlined by the Centers for Disease Control and the American Academy of Pediatrics which has been scientifically tested for safety and efficacy.

There is no such thing as a tested or safe "alternative" vaccine schedule. We will be happy to provide information to help you understand the science behind vaccines, but we have a commitment to our patients to keep them safe and provide the best pediatric care available. This includes giving vaccinations on time, according to the CDC/AAP schedule.

For more information on vaccines: <https://www.chop.edu/centers-programs/vaccine-education-center>

For more information on vaccine safety: <https://www.cdc.gov/vaccinesafety/index.html>

Antibiotics:

We work hard to not overuse antibiotics. We educate families on appropriate use of antibiotics, and follow evidence-based guidelines. We don't automatically treat ear pain or a green snotty nose with antibiotics. We do not call in antibiotics over the phone as we do not believe that is good medicine. When we believe antibiotics are appropriate treatment, we will be happy to answer your questions. Together we can create a healthier community.

For more information on appropriate antibiotic use: https://www.cdc.gov/antibiotic-use/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fantibiotic-use%2Fcommunity%2Findex.html

Medical Home:

We work hard to provide comprehensive medical care and serve as your medical home. To that end, we expect that you contact our office FIRST before seeking specialty care, or heading to Urgent Care. If your question or concern occurs after hours, we have a Nurse Advice Line that can help! We are happy to direct you to the most appropriate place for care.

Technology:

Our practice prides itself on efficiency through use of technology. You will be expected to contact us through our patient portal and effectively use automated reminders and patient engagement enabled via technology. We also use a secure texting service which makes getting in touch with us super easy! Let's stay connected!

Office Hours:

We make every effort to meet the needs of our patients, but we do not have evening or weekend hours. We are open Monday-Friday 8:30am-5:00pm. We are closed on major holidays and may have closures on other days around the holidays, which will be announced.

After Hours:

If you need to speak with a nurse outside of our normal working hours, we encourage you to contact the Children's Medical Center Nurse Advice Line at 1-855-456-6976. There is no charge for this service. Unless it is a true medical emergency (in which case you should call 911), we encourage you to use this service to discuss recommendations prior to heading to the Emergency Department or Urgent Care. These Nurses are excellent in helping with pediatric concerns and call the back up doctor or nurse practitioner if they are unsure of what to advise. Our office will follow up with you after you call this Nurse Advice Line.

Specialist Care:

As your medical home we expect that you will contact our office to discuss care plans before scheduling an appointment with a specialist. We want to be involved in either providing care in our office where appropriate, or referring you to the most appropriate specialist and helping coordinate your care. Whenever you do see a specialist, we ask that you request a report be sent directly to our office so we can understand everything that has been recommended for your child.

Appointments:

Appointments may be scheduled with the nurse practitioners or with Dr Tomberlin. As Dr Tomberlin's schedule gets filled in advance, urgent visits will be with a nurse practitioner most often. We will always try to accommodate advance appointment requests for a specific provider, but cannot guarantee that your child will be seen by a specific provider. We do not have walk-in hours. Please call our office to make an

appointment and tell the staff all of your concerns so that they can allow the appropriate length of time. For your convenience, we do have some self scheduling options for established patients only.

Prescription Refills:

All verbal refill requests must be made during office hours. Please give at least 3 business days for refills to be completed or 7 business days for controlled medications (like ADHD medications) to be refilled.

Medical Forms:

We will need 7 business days to complete all medical forms, including but not limited to all daycare, school, physical, and medication administration forms. There is a fee for completing all forms, unless the parent provides the needed form at the child's visit.

Insurance:

Please make sure we take your specific insurance plan. To do this, call our office and/or check with your specific insurance company. We will bill the insurance companies with whom we are contracted. Payment is expected at the time of service for any copays and deductibles not covered by your plan. We accept cash, check and credit cards (Visa, Master Card, American Express, and Discover). There is a \$50 charge for returned checks.

We do NOT accept Medicaid. If you have secondary Medicaid and a primary insurance, we may still be able to see your child. Please call the office for clarification in this circumstance.

Billing:

It is up to you to understand how your insurance works including deductibles and co-insurance and to provide up-to-date insurance information at every visit.

Fees:

Our office fees are as follows:

LATE: We believe everyone's time is valuable; therefore our practice makes every effort to run on time. We ask that you make every effort to present to the office at your scheduled appointment time and call us if you are running behind. We reserve the right to reschedule if you have missed your scheduled appointment time. Arriving late to your appointment incurs a \$25 fee.

NO SHOW: No show appointments will be charged \$50 for each missed sick appointment and \$100 for each missed well check appointment. Your child(ren) will be dismissed after the 3rd missed appointment for your family. Failure to complete required check in forms within the required time frame will incur a no show fee and the appointment will automatically be cancelled. We will not reschedule new patients who no show their first appointment.

CANCELLATIONS: A \$25 fee will be charged for each appointment that is cancelled within 24 hours of the appointment.

***Automated appointment reminders are a courtesy only and should not be relied upon for keeping your child's appointment.

Signature _____ Date _____



CHILDREN OF DIVORCED PARENTS

Responsibility for payment for treatment of minor children whose parents are divorced rests with the parent who brings the child(ren) into the office. Any court ordered responsibility judgment must be determined between the individuals involved WITHOUT the inclusion of JULIE TOMBERLIN MD PA. I have completed this form fully and certify that I am the patient or authorized agent of the patient, authorized to furnish all the information requested. I understand that even though I have insurance coverage, I am responsible for payment of services rendered. I hereby assign to the above named doctor/practice all benefits, rights and proceeds for services rendered under any insurance policies or any reimbursement or prepaid healthcare plans. I hereby authorize the release of pertinent information to insurance carriers and agree to pay all charges incurred.

I ACKNOWLEDGE THAT THE OFFICE OF JULIE TOMBERLIN MD PA DOES NOT ACCEPT PATIENTS WHO CARRY MEDICAID AS PRIMARY OR SECONDARY COVERAGE. AS THE OFFICE IS NOT IN NETWORK WITH MEDICAID, WE ARE UNABLE TO APPROPRIATELY FILE CLAIMS FOR PATIENTS WITH THIS COVERAGE. IF YOUR CHILD HAS MEDICAID COVERAGE, EVEN IF IT IS NOT THE PRIMARY COVERAGE, WE WILL NOT BE ABLE TO ESTABLISH CARE FOR THEM.

DISCLAIMER: By typing your name below, you are signing this application electronically in agreement with the above policies and statements. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Printed Name of Patient _____ Date _____

Signature of Parent/Guardian _____

Printed Name of Parent/Guardian _____



Record Release Form

I authorize the release of records from my previous physician:

Yes No

Previous Physician/Clinic Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

I hereby authorize the release of all necessary medical records to:

Julie Tomberlin MD PA
706 Hunters Row Ct.
Mansfield, TX 76063
Phone: 682-518-8111 / Fax: 682-518-8112
office@jt-md.net

DISCLAIMER: By typing your name below, you are signing this application electronically in agreement with the above policies and statements. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Printed Name of Patient _____ Date _____

Signature of Parent/Guardian _____

Printed Name of Parent/Guardian _____



Financial Policy and Patient Consent Form

The following is provided to avoid any misunderstanding concerning payment for medical services.

1. Payment

Payment is expected at the time of service.

You are responsible for any balance after insurance processes your claim.

Any balance remaining after insurance processes the claim is billed to the responsible party indicated on the account. Accounts not paid in full after 90 days will be referred to an outside collection agency or paid using Credit Card on File information.

2. Managed Care

All managed care (HMO, PPO, etc.) copayment amounts are due at the time of service.

This office does not set copayment amounts.

This office collects \$125 per visit for ALL plans with deductibles that apply to medical office visits. This is an ESTIMATE of the cost of the visit. Any balance will be billed and any overpayment will be credited to the account once the claim has been processed.

3. Children of Divorced Parents

The parent or guardian who brings the child for any visits is the responsible party.

Responsibility for payment for treatment of minor children whose parents are divorced rests with the parent who is in our office building at the time of treatment.

This parent is required to pay for services rendered regardless of what a divorce decree may state. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Julie Tomberlin MD PA

It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies, please call us at (682) 518-8111.

Disclaimer: By typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.

Cashless Office Policy:

To improve safety, efficiency, and the patient experience, our practice will transition to a cashless payment model effective June 1, 2026.

Beginning on this date, our office will no longer accept cash payments.

Accepted Forms of Payment:

*Credit cards (Visa, MasterCard, American Express, Discover)

*Debit cards

*HSA/FSA cards

*Secure electronic payment links (text/email)

Payment Expectations:

*Copays and self-pay charges are due at the time of service

*Balances after insurance processing are due upon notification and can be paid using our secure payment link or by card in the office

*Form fees and administrative fees will be collected prior to completion per our financial policy

Missed appointment / late cancellation fees will be charged according to our existing office policy

*Receipts will be provided electronically.

If a parent or guardian is not present at the visit, we will:

Contact the parent/guardian to obtain payment by phone, or

Send a secure electronic payment link

Unpaid Balances:

Accounts with unpaid balances may be subject to our standard billing procedures and policies, including possible limitations on non-urgent scheduling until the account is current.

Questions:

If you have any questions about this policy, please contact our office at 682-518-8111.

We appreciate your understanding and partnership as we continue to streamline our processes and provide high-quality, efficient care for your family.

Signature : _____

Date: _____



Billing Summary / Benefits Policy

Our office will accept an assignment of benefits from your insurance company with the following provisions:

1. Filing claims through insurance does not eliminate the financial obligation for the medical service my child or I have received.
2. Copay, deductible and coinsurance amounts are due in full at the time of service. We do not waive collection of these fees in exchange for medical services. Payment of any remaining balance is due after your insurance company processes the claim or as provided below.
3. If we have not received payment after 90 days, we will charge the credit card we have on file OR we will forward the balance to a third-party collection agency.
4. If your claim is denied, you will be responsible for paying the self-pay or cash balance plus full cost of all medical supplies.
5. Our office will NOT enter into a dispute with your insurance company for any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY HEALTH BENEFITS DIRECTLY TO THE OFFICE OF JULIE TOMBERLIN MD PA OR TEXAS HEALTH CARE PLLC (PRIVIA)

DISCLAIMER: By typing your name below, you are signing this application electronically in agreement with the above policies and statements. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Signature _____ Date _____



Patient Consent for Disclosure of Information

I have read the Notice of Privacy Practices and have had any questions answered by this office. I understand that by signing this form, I consent to the following:

- Sharing Information For Purpose Of Treatment: You will share information with all members of my treatment team, both within this office and with our providers (personal and institutional) in order to provide me with quality care and educational/wellness programs specified in my insurance plan;
- Sharing Of Information For Purposes Of Payment: You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies;
- Sharing Of Information For Purposes Of Operations: You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing process, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

DISCLAIMER: By typing your name below, you are signing this application electronically in agreement with the above policies and statements. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Signature _____ Date _____



Non-Guardian Adults Authorized to Accompany a Minor

There are no court orders currently in effect which would prohibit me from exercising the power that I now seek to convey.

In the event that I am absent and unable to provide consent at the time:

- I hereby consent to and authorize any urgent or emergency medical, dental, or diagnostic procedure and/or treatment, surgical care and/or hospitalization that my child(ren)'s health care provider determines, in his or her best judgment, is necessary for the health and well-being of my child(ren), including, but not limited to, provision of prescription and non-prescription medication.
- In my absence, I authorize my child(ren)'s health care provider to disclose my child(ren)'s medical information to the individual(s) designated below as necessary for such individual(s) to assist in the care of my child(ren).
- In my absence, I request that my child(ren)'s health care provider discuss my child(ren)'s health needs with the individual(s) designated below;
- In my absence, I authorize those persons, to the extent state law permits me to do so, to care for my child(ren) and to consent to recommended care and treatment for my child(ren).
- I designate the individual(s) on the following list, in the order of priority listed, to act on my behalf when I am not reasonably available to provide consent necessary for any non-urgent or non-emergency medical, dental, or diagnostic procedure and/or treatment for my child(ren):

In the event I cannot be reached in an emergent situation I authorize my child(ren)'s health care provider to act in the best interest and wellbeing of my child(ren).

To the extent I have authorized the above individual(s) to act on my behalf in my absence, I hereby release and hold harmless my child(ren)'s health care providers, including any physician, hospital or hospital personnel, or other health care provider rendering care to my child(ren), arising from the failure to obtain consent from me.

Name _____

Signature _____ Date _____

Authorized person's name _____ Phone number _____



Texas Medical Board – Complementary & Alternative Medicine (CAM)

Treatment Disclosure & Consent (22 TAC §171.2(b))

Patient Information

Patient Name: _____ DOB: _____

MRN: _____

Physician Information

Physician Name (MD/DO): _____ License #: _____

Please see encounter notes for all information listed below.

Condition(s)

Condition(s) being treated with CAM therapy: _____

Proposed CAM Treatment(s)

Description of CAM treatment(s): _____

Assessment

Medical history, exam, and prior conventional treatments reviewed. _____

Required Disclosures

Objectives, risks/benefits, alternatives, mechanism of action, regulatory status, and reassessment plan reviewed. _____

Regulatory Status

FDA-approved / Off-label / Compounded / DSHEA supplement / Not FDA regulated

Individualized Treatment Plan

Plan and monitoring strategy: _____

Patient Acknowledgment

I acknowledge the above disclosures and consent to CAM treatment.

Signatures

Patient/Guardian Signature: _____ Date: _____

Physician Signature: J. Tombeilink _____ Date: _____



JTMD Pediatric Office Wegovy Weight Loss Medication Waiver

Waiver and Informed Consent

Patient's Name: _____

Date of Birth: _____

Parent/Guardian's Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

1. Introduction:

Wegovy (semaglutide) is a prescription medication approved by the FDA for chronic weight management in children aged 12 and older. This waiver and informed consent form are designed to provide information about Wegovy, its potential benefits, and its risks, ensuring that you make an informed decision regarding its use for your child.

2. Description of Medication:

Wegovy is a glucagon-like peptide-1 (GLP-1) receptor agonist that works by regulating appetite and food intake. It is administered via subcutaneous injection once weekly.

3. Potential Benefits:

Significant weight loss
Improved control of obesity-related conditions (e.g., type 2 diabetes, hypertension)
Enhanced overall health and well-being

4. Potential Risks and Side Effects:

Nausea, vomiting, diarrhea, constipation
Abdominal pain, dyspepsia
Hypoglycemia, especially if used with other diabetic medications
Pancreatitis
Gallbladder disease
Thyroid cancers
Increased heart rate
Injection site reactions
Possible allergic reactions

5. Medical Supervision:

Regular follow-up appointments are required to monitor the patient's progress, side effects, and overall health. It is crucial to adhere to the prescribed dosage and follow the healthcare provider's recommendations.

6. Consent:

I, the undersigned parent/guardian, have been fully informed about the nature, benefits, and risks of using Wegovy for weight loss in my child. I understand that while this medication is FDA-approved for pediatric use in children aged 12 and older, there may still be unknown long-term effects. The long-term safety and efficacy of Wegovy in children and adolescents have not been established.

I acknowledge that the decision to use Wegovy for my child is voluntary and made with the understanding of the potential risks involved. I agree to follow the healthcare provider's instructions and to attend all scheduled appointments for monitoring my child's condition.

I hereby release the pediatric office, its healthcare providers, and staff from any liability arising from the use of Wegovy in my child, understanding that all possible precautions will be taken to ensure my child's safety.

7. Parent/Guardian's Acknowledgment:

I have read and understand the information provided in this waiver. All my questions regarding the use of Wegovy for my child have been answered to my satisfaction.

Signature of Parent/Guardian: _____

Date: _____

By signing this waiver, you are confirming your understanding and acceptance of the information provided, and you are agreeing to proceed with the use of Wegovy for your child's weight management under medical supervision.

Contact Information:

If you have any questions or concerns regarding this waiver or the use of Wegovy, please contact our office at 682-518-8111 or office@jt-md.net.



Julie Tomberlin MD PA Pediatrics Vaccine Policy

At Julie Tomberlin MD PA Pediatrics, we believe vaccines are essential to protecting your child—and our community—from preventable diseases. We follow the immunization schedule recommended by the American Academy of Pediatrics (AAP), which reflects the most current, evidence-based medical guidance.

You can review the recommended schedule here:

<https://downloads.aap.org/AAP/PDF/AAP-Immunization-Schedule>

We understand some parents may have questions or concerns about vaccine timing. If you are considering an alternative schedule, a consultation with Dr Tomberlin is required. This is a billable medical service and may or may not be covered by your insurance.

If an alternative plan is agreed upon, both the provider and parent must commit to it.

Families choosing a delayed or modified schedule assume full responsibility for the added risks, including:

- *Delayed protection against illness
- *More clinic visits and potential exposure
- *Greater chance of scheduling or vaccine errors in non-standard plans

Immunization-only visits may involve longer wait times, particularly if we are short-staffed. Our clinic is structured to prioritize scheduled, in-person care. Our goal is to provide every child maximum protection at the earliest and safest age, which is why we advocate for the routine immunization schedule. Each additional immunization only visit will require a \$25 fee. This fee is not covered by insurance.

We expect all patients to be up-to-date by their next well visit unless a valid medical exemption is documented. We do not provide non-medical vaccine exemptions.

We are committed to partnering with families to address vaccine concerns with compassion, education, and respect. However, in order to provide a safe environment for all patients—especially those who are too young or medically unable to be vaccinated—we have made the decision not to maintain professional medical relationships with families who reject our vaccine policy.

Thank you for trusting us with your child's care. We are honored to be part of your child's health journey.

Warmly,
Julie Tomberlin MD
Board Certified in Pediatrics and Integrative Medicine

Parent signature and acknowledgement: _____ Date: _____

CHILDREN'S HEALTH



CONSENT
CMC82898-001NS Rev. 6/2018

Consent for Behavioral Health
Screening and Treatment
(Physician Recommendation)

Patient Name: _____ Date of Birth: _____

Pediatrician Name: Julie Tomberlin MD

Behavioral Health Care Manager: Sierra McFan LCSW

Reason for Referral: _____

Parent/Guardian Phone Number: _____ Patient's Phone Number (if 18 years of age or older): _____

I am the Patient or Legally Authorized Representative (e.g. mother / father / guardian) of the Patient. At the recommendation of the Patient's pediatrician as part of Patient's treatment plan, I request and consent for Patient to be seen by a Behavioral Health Care Manager (BHCM), who is a Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Marriage and Family Therapist at a Children's Health System of Texas hospital, facility, entity or program ("Children's Health"). I understand that Patient's treatment by a Children's Health BHCM is specific to behavioral health assessment, short-term treatment, case management and / or consulting services and is not a substitute for medical treatment. The BHCM working with the Patient will keep me informed regarding the behavioral health services being provided and the anticipated duration of services. I understand that Children's Health is a separate provider of services and the Children's Health BHCM is not an employee or under the control of Patient's pediatrician. I understand, the initial telephonic assessment and ongoing telephonic case management are provided at no cost to me and my child. No services which generate a bill will be provided to me or my child without my written permission.

The Children's Health behavioral health services are intended to support the behavioral health needs of the Patient. The BHCM working with the Patient will not complete evaluations for the purpose of determining fitness for parental custody and will not make recommendations regarding custody. It is agreed by signing this consent that the Patient and the Patient's legal guardians will not call or subpoena the Children's Health BHCM to testify in a custody dispute.

I understand that Children's Health, the BHCM, Patient's pediatrician and other providers may share, exchange and disclose information about Patient including Patient's protected health information (PHI) for treatment, payment and operational purposes and I authorize such use and disclosures by electronic and other methods. This authorization includes the disclosure of Patient's diagnoses, history, medical condition and / or treatment and may include information related to genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), records related to mental health treatment / psychiatric care and alcohol / substance abuse diagnosis or treatment.

I understand that I can revoke this consent at any time by providing notice to the Children's Health BHCM.

Signature of Patient / Legally Authorized Representative _____ Date _____ Time _____

Printed Name of Patient / Legally Authorized Representative _____ Relationship to Patient _____

Signature of Witness / Interpreter _____ Date _____ Time _____

Printed Name of Witness / Interpreter _____
Julie Tomberlin MD
*If telephone translation, name of interpreter, ID number and Translation Services vendor

Signature of Provider Obtaining Consent _____ Date _____ Time _____
Julie Tomberlin MD
Credentials

Printed Name of Provider Obtaining Consent _____



Media Release Consent Form

PATIENT MEDIA RELEASE AUTHORIZATION

I, the undersigned parent or legal guardian of the minor child listed below, authorize Julie Tomberlin MD PA, including its physicians, nurse practitioners, employees, agents, and representatives, to photograph, video record, and/or otherwise capture images or recordings of my child for marketing, educational, informational, and promotional purposes.

I understand that these materials may be used in:

- Social media posts and stories
- The practice website
- Printed marketing materials
- Educational materials
- Advertisements
- Office displays
- Other electronic or digital communications

I understand that:

- My child's first name may be used, but no protected health information (PHI) or identifying medical information will be disclosed without additional authorization.
- Images and recordings may be edited, copied, displayed, published, or distributed.
- Once materials are posted online or on social media, the practice cannot fully control further sharing or distribution by third parties.
- I will not receive compensation for the use of these materials.

I understand that participation is voluntary and that refusal to agree this form will not affect my child's medical care in any way.

I may revoke this authorization at any time by submitting written notice to the practice. However, I understand that materials already published or distributed prior to revocation may not be able to be removed or recalled.

_____ I authorize use of photos/images only

_____ I authorize use of video recordings

_____ I authorize use of my child's first name with media

_____ I DO NOT authorize use of my child's name

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____