



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: 60px; 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: 60px; 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"/> | ___ |

PROBLEM SOLVING (continued)

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.)

3 1 2

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

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

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

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.)

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.)

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?)

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

- | | |
|---|---|
| <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?

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

PERSONAL-SOCIAL TOTAL —

OVERALL

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

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

YES NO

OVERALL (continued)

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