Parents: Staff will complete this page.

ASQ-3 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: _____

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

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

Program name: _____

P101160100

Bright Futures Parent Supplemental Questionnaire 15 Month Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please circle Yes or No for each question. Thank you.

Talking and Feeling: Communication and Social Development

Do you help your child feel comfortable around new people?	Yes	No
Do you talk with others about parenting issues?	Yes	No
Do you take time for yourself?	Yes	No
Do you spend time alone with your partner?	Yes	No
Do you talk to, sing to, and look at books with your child every day?	Yes	No
Can your child tell you what she wants by pulling and pointing?	Yes	No
Does your child play actively for one hour or more a day?	Yes	No
Are you worried about your child's weight?	No	Yes
How many hours per day does your child watch TV?	_____ hours	

A Good Night's Sleep: Sleep Routines and Issues

Does your child have a regular bedtime routine?	Yes	No
Do you let your child fall asleep on his own?	Yes	No
Does your child have a blanket, stuffed animal, or toy that she likes to sleep with?	Yes	No

Temper Tantrums and Discipline

If your child is upset, do you help change his focus to another activity, book, or toy?	Yes	No
Do you set limits for your child?	Yes	No
Do you and other caregivers set the same limits for your child?	Yes	No
Do you teach your child the right way to act?	Yes	No
Do you praise your child when she is being good?	Yes	No

Healthy Teeth

Has your child been to a dentist?	Yes	No
Do you brush your child's teeth with water 2 times a day, using a soft toothbrush?	Yes	No
Does your child use a bottle?	No	Yes
Does your child use a bottle in bed?	No	Yes

Safety

Do you always use a car safety seat in the back seat of the car?	Yes	No
Are you having any problems with your car safety seat?	No	Yes
Do you keep cleaners and medicines locked up?	Yes	No
Do you have the number for poison control near every telephone?	Yes	No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	Yes	No
Does anyone smoke around your child?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No
Do you keep your child away from the stove?	Yes	No
Do you have a working smoke and carbon monoxide detector on every floor of your home?	Yes	No
Do you have a fire escape plan?	Yes	No
Do you know if the temperature of your hot water heater is below 120°F?	Yes	No

Bright Futures Medical Screening Questionnaire
15 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child speaks?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Have your child's eyes ever been injured?	Y	N	Unsure
Does your child hold objects close when trying to focus?	Y	N	Unsure
Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	Y	N	Unsure
Do your child's eyelids droop or does one eyelid tend to close?	Y	N	Unsure

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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?	○	○	○	___
2. Does your child say four or more words in addition to "Mama" and "Dada"?	○	○	○	___
3. When your child wants something, does she tell you by *pointing* to it?	○	○	○	___
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.")*	○	○	○	___
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.)*	○	○	○	___
6. Does your child say eight or more words in addition to "Mama" and "Dada"?	○	○	○	___
			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?	○	○	○	___
2. Does your child climb onto furniture or other large objects, such as large climbing blocks?	○	○	○	___
3. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	○	○	○	___

GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your child move around by walking, rather than crawling on her hands and knees?	○	○	○	___
5. Does your child walk well and seldom fall?	○	○	○	___
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)?	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

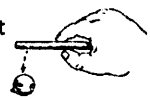
	YES	SOMETIMES	NOT YET	
1. Does your child help turn the pages of a book? *(You may lift a page for her to grasp.)*	○	○	○	___
2. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	○	○	○	___
3. Does your child stack a small block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

FINE MOTOR TOTAL ___

PROBLEM SOLVING

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

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? 	○	○	○	___
5. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?	○	○	○	___ *
6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump it out? *(You may show her how.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

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

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child feed himself with a spoon, even though he may spill some food?	○	○	○	___
2. Does your child help undress herself by taking off clothes like socks, hat, shoes, or mittens?	○	○	○	___
3. Does your child play with a doll or stuffed animal by hugging it?	○	○	○	___
4. While looking at himself in the mirror, does your child offer a toy to his own image?	○	○	○	___
5. Does your child get your attention or try to show you something by pulling on your hand or clothes?	○	○	○	___
6. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?	○	○	○	___

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

Bright Futures Parent Handout
15 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

COMMUNICATION AND SOCIAL DEVELOPMENT

Talking and Feeling

- Show your child how to use words.
  - Use words to describe your child's feelings.
  - Describe your child's gestures with words.
  - Use simple, clear phrases to talk to your child.
  - When reading, use simple words to talk about the pictures.
- Try to give choices. Allow your child to choose between 2 good options, such as a banana or an apple, or 2 favorite books.
- Your child may be anxious around new people; this is normal. Be sure to comfort your child.

SLEEP ROUTINES AND ISSUES

A Good Night's Sleep

- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Put your child to bed at the same time every night. Early is better.
- Try to tuck in your child when she is drowsy but still awake.
- Avoid giving enjoyable attention if your child wakes during the night. Use words to reassure and give a blanket or toy to hold for comfort.

SAFETY

Safety

- It is best to keep your child's car safety seat rear-facing until she reaches the seat's weight or height limit for rear-facing use. Do not switch your child to a forward-facing car safety seat until she is at least 1 year old and weighs at least 20 pounds.
- Follow the owner's manual to make the needed changes when switching the car safety seat to the forward-facing position.
- Never put your child's rear-facing seat in the front seat of a vehicle with a passenger airbag. The back seat is the safest place for children to ride
- Everyone should wear a seat belt in the car.
- Lock away poisons, medications, and lawn and cleaning supplies.
- Call Poison Help (1-800-222-1222) if you are worried your child has eaten something harmful.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher. Keep furniture away from windows.
- Keep your child away from pot handles, small appliances, fireplaces, and space heaters.
- Lock away cigarettes, matches, lighters, and alcohol.
- Have working smoke and carbon monoxide alarms and an escape plan.
- Set your hot water heater temperature to lower than 120°F.

TEMPER TANTRUMS AND DISCIPLINE

Temper Tantrums and Discipline

- Use distraction to stop tantrums when you can.
- Limit the need to say "No!" by making your home and yard safe for play.
- Praise your child for behaving well.
- Set limits and use discipline to teach and protect your child, not punish.
- Be patient with messy eating and play. Your child is learning.
- Let your child choose between 2 good things for food, toys, drinks, or books.

HEALTHY TEETH

Healthy Teeth

- Take your child for a first dental visit if you have not done so.
- Brush your child's teeth twice each day after breakfast and before bed with a soft toothbrush and plain water.
- Wean from the bottle; give only water in the bottle.
- Brush your own teeth and avoid sharing cups and spoons with your child or cleaning a pacifier in your mouth.

What to Expect at Your Child's 18 Month Visit

We will talk about

- Talking and reading with your child
- Playgroups
- Preparing your other children for a new baby
- Spending time with your family and partner
- Car and home safety
- Toilet training
- Setting limits and using time-outs

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org

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Parents: Staff will complete this page.

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

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						

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