



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



Bright Futures Parent Supplemental Questionnaire

3 Year 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.

Family Support

| | | | |
|--|-----|-----|----|
| Do your family members show love to one another? | | Yes | No |
| Do you immediately stop your child from hitting or biting others? | | Yes | No |
| Do you and other caregivers set the same limits for your child? | | Yes | No |
| Do you allow your child to make choices like what clothes to wear or what books to read? | | Yes | No |
| Do you spend time alone with each of your children? | N/A | Yes | No |
| Do you try to settle fights between your children without taking sides? | N/A | Yes | No |
| Do you take time for yourself? | | Yes | No |
| Do you feel you are able to balance family and work? | | Yes | No |
| Do you spend time alone with your partner? | | Yes | No |

Reading and Talking With Your Child: Encouraging Literacy Activities

| | | | |
|---|--|-----|----|
| Do you read, sing songs, or play word games with your child every day? | | Yes | No |
| When you are reading together, do you ask your child questions about the pictures or story? | | Yes | No |
| Do you ask your child to talk about her day? | | Yes | No |

Playing With Others: Playing With Peers

| | | | |
|--|--|-----|----|
| Does your child have chances to play with other children, like on playdates or at preschool? | | Yes | No |
| When your child plays with other children, do you help him learn how to take turns? | | Yes | No |
| Is your child in preschool or child care? | | Yes | No |
| Do you have plans for child care or preschool in the next year? | | Yes | No |



Your Active Child: Promoting Physical Activity

| | | |
|---|-----|-----|
| Does your child watch TV more than 2 hours a day? | No | Yes |
| Are you physically active together as a family, like going on walks or playing in the park? | Yes | No |
| Does your child play actively for at least one hour per day? | Yes | No |

Safety

| | | |
|---|-----|-----|
| Do you always use a car safety seat in the back seat of the car? | Yes | No |
| Do you ever leave your child alone in the car, house, or yard? | No | Yes |
| Do you watch your child closely when she plays near streets or driveways? | Yes | No |
| Do you have furniture away from windows and window guards on all windows on the second floor or higher? | Yes | No |
| When your child plays outside, do you make sure that he stays within fences and gates? | Yes | No |
| Does anyone in your home or the homes where your child spends time have a gun? | No | Yes |
| If so, are the guns unloaded and locked away with the ammunition locked separately from the gun? | N/A | No |
| Does anyone smoke around your child? | No | Yes |
| If you smoke, would you like information on how to stop? | Yes | No |



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.



Bright Futures Medical Screening Questionnaire

3 Year 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 |
| Does your child have a sibling or playmate who has or had lead poisoning? | Y | N | Unsure |
| Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled? | Y | N | Unsure |
| Does your child live in or regularly visit a house or child care facility built before 1950? | Y | N | Unsure |
| Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)? | Y | N | Unsure |
| Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis? | Y | N | Unsure |
| Has a family member or contact had tuberculosis or a positive tuberculin skin test? | Y | N | Unsure |
| Is your child infected with HIV? | Y | N | Unsure |
| Do you ever struggle to put food on the table? | Y | N | Unsure |
| Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans? | N | Y | Unsure |
| Does your child have a dentist? | N | Y | Unsure |
| Does your child's primary water source contain fluoride? | N | Y | Unsure |



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.



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:

Notes:

- 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 _____.

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.)
2. Does your child make sentences that are three or four words long? Please give an example:
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?
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?"
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"?
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"/> | <input type="checkbox"/> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> |

COMMUNICATION TOTAL _____

GROSS MOTOR

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



| YES | SOMETIMES | NOT YET | ___ |
|-----------------------|-----------------------|-----------------------|-----|
| <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?



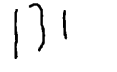
| | | | |
|-----------------------|-----------------------|-----------------------|-----|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
|-----------------------|-----------------------|-----------------------|-----|

GROSS MOTOR TOTAL ___

FINE MOTOR

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?

Count as "yes"



Count as "not yet"



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

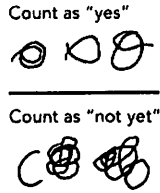
FINE MOTOR (continued)

YES SOMETIMES NOT YET

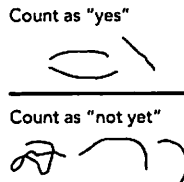
2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?



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?



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?



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.)



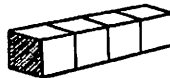
6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?

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.)



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)?

PROBLEM SOLVING (continued)

YES SOMETIMES NOT YET

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.)

PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

YES SOMETIMES NOT YET

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?

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



Bright Futures Parent Handout 3 Year Visit

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

ENCOURAGING LITERACY ACTIVITIES

Reading and Talking With Your Child

- Read books, sing songs, and play rhyming games with your child each day.
- Reading together and talking about a book's story and pictures helps your child learn how to read.
- Use books as a way to talk together.
- Look for ways to practice reading everywhere you go, such as stop signs or signs in the store.
- Ask your child questions about the story or pictures. Ask him to tell a part of the story.
- Ask your child to tell you about his day, friends, and activities.

PROMOTING PHYSICAL ACTIVITY

Your Active Child

Apart from sleeping, children should not be inactive for longer than 1 hour at a time.

- Be active together as a family.
- Limit TV, video, and video game time to no more than 1–2 hours each day.
- No TV in your child's bedroom.
- Keep your child from viewing shows and ads that may make her want things that are not healthy.
- Be sure your child is active at home and preschool or child care.
- Let us know if you need help getting your child enrolled in preschool or Head Start.

FAMILY SUPPORT

Family Support

- Take time for yourself and to be with your partner.
- Parents need to stay connected to friends, their personal interests, and work.
- Be aware that your parents might have different parenting styles than you.
- Give your child the chance to make choices.
- Show your child how to handle anger well—time alone, respectful talk, or being active. Stop hitting, biting, and fighting right away.
- Reinforce rules and encourage good behavior.
- Use time-outs or take away what's causing a problem.
- Have regular playtimes and mealtimes together as a family.

SAFETY

Safety

- Use a forward-facing car safety seat in the back seat of all vehicles.
- Switch to a belt-positioning booster seat when your child outgrows her forward-facing seat.
- Never leave your child alone in the car, house, or yard.
- Do not let young brothers and sisters watch over your child.
- Your child is too young to cross the street alone.
- Make sure there are operable window guards on every window on the second floor and higher. Move furniture away from windows.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun. Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.
- Supervise play near streets and driveways.

PLAYING WITH PEERS

Playing With Others

Playing with other preschoolers helps get your child ready for school.

- Give your child a variety of toys for dress-up, make-believe, and imitation.
- Make sure your child has the chance to play often with other preschoolers.
- Help your child learn to take turns while playing games with other children.

What to Expect at Your Child's 4 Year Visit

We will talk about

- Getting ready for school
- Community involvement and safety
- Promoting physical activity and limiting TV time
- Keeping your child's teeth healthy
- Safety inside and outside
- How to be safe with adults

Poison Help: 1-800-222-1222

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



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

Parents: Staff will complete this page.

Nursing: perform visual acuity screen @ 36 months.



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.

- | | |
|---|---|
| <p>1. Hears well? Yes NO Comments: _____</p> <p>2. Talks like other children his age? Yes NO Comments: _____</p> <p>3. Understand most of what your child says? Yes NO Comments: _____</p> <p>4. Others understand most of what your child says? Yes NO Comments: _____</p> <p>5. Walks, runs, and climbs like other children? Yes NO Comments: _____</p> | <p>6. Family history of hearing impairment? YES No Comments: _____</p> <p>7. Concerns about vision? YES No Comments: _____</p> <p>8. Any medical problems? YES No Comments: _____</p> <p>9. Concerns about behavior? YES No Comments: _____</p> <p>10. Other concerns? YES No Comments: _____</p> |
|---|---|

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 | | | | | | |