



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: _____



Bright Futures Parent Supplemental Questionnaire 5 and 6 Year Visits

For us to provide 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.

Ready for School: School Readiness

Does your child go to school?	N/A	Yes	No
Do you know your child's teacher?		Yes	No
Are you able to attend your child's school functions?		Yes	No
Are you happy with your child's after-school care?		Yes	No
Do you have any concerns about your child doing well in school?		No	Yes
Do you know what signs to look for if your child is being bullied or teased?		Yes	No
Does your child receive any special education services?		No	Yes

Your Child and Family: Mental Health

Do you have special family activities, traditions, or routines?		Yes	No
Do you discipline your child to teach good behavior and not to punish?		Yes	No
Does your child do simple chores around the house?		Yes	No
Do you help your child control his anger?		Yes	No
Does your child fix problems with words and not violent behavior like biting or hitting?		Yes	No
Does your child get along with her friends?		Yes	No

Staying Healthy: Nutrition and Physical Activity

Does your child eat breakfast every day?		Yes	No
Does your child eat at least 5 servings of fruits and vegetables a day?		Yes	No
Does your child drink at least 3 servings of low-fat milk a day or eat yogurt or cheese?		Yes	No
Do you limit foods that are high in fat like candy, soft drinks, salty snacks, and fast food?		Yes	No
Do you have any concerns about your child's weight?		No	Yes
Is your child active at least 1 hour every day?		Yes	No
Does your child watch TV, play video games, or use the computer (not for schoolwork) for more than 2 hours a day?		No	Yes



Healthy Teeth: Oral Health

Does your child brush his teeth twice a day?	Yes	No
Does your child floss her teeth once a day?	Yes	No
Does your child see a dentist at least twice a year?	Yes	No

Safety

Do you always use a car safety seat or a booster seat in the back seat of all vehicles?	Yes	No	
Does your child know street safety such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?	Yes	No	
Does your child always wear a helmet and other protective gear when biking, skating, horseback riding, skiing, or snowboarding?	Yes	No	
Does your child know how to swim and only swim when an adult is watching?	Yes	No	
Do you always put sunscreen on your child before he goes outside to play or swim?	Yes	No	
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?	Yes	No	
Does your child know that is it never okay for an older child or adult to ask to see his private parts?	Yes	No	
Does your family have and practice an escape plan in case a fire starts in your home?	Yes	No	
Are there smoke and carbon monoxide detectors on every floor of your house?	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	Yes	No
Does anyone smoke around your child?	No	Yes	
If you smoke, would you like information on how to stop?	Yes	No	



**American Academy
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DEDICATED TO THE HEALTH OF ALL CHILDREN™

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60 Month Questionnaire

57 months 0 days
through 66 months 0 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. 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"/>	___
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				
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"/>	___
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				
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"/>	___
<div style="border: 1px solid black; border-radius: 15px; height: 60px; width: 100%;"></div>				

COMMUNICATION (continued)

YES SOMETIMES NOT YET _____

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:

"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:

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

YES SOMETIMES NOT YET _____

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.")



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.)




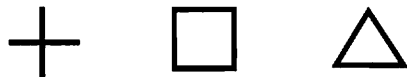
GROSS MOTOR (continued)

- | | 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 her 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: 30%; 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	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.)

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

(Space for adult's printing)

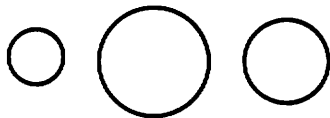
(Space for child's printing)

FINE MOTOR TOTAL —

PROBLEM SOLVING

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

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.)



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"/>	<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."
 YES SOMETIMES NOT YET _____
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 *hard*, and a pillow is *soft*."
 YES SOMETIMES NOT YET _____

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.)
 YES SOMETIMES NOT YET _____

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.)
 YES SOMETIMES NOT YET _____

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?
 YES SOMETIMES NOT YET _____
2. Does your child wash her hands and face using soap and water and dry off with a towel without help?
 YES SOMETIMES NOT YET _____
3. Does your child tell you at least four of the following? Please mark the items your child knows.
- a. First name d. Last name
- b. Age e. Boy or girl
- c. City he lives in 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? (<i>She goes to the bathroom, sits on the toilet, wipes, and flushes.</i>) 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



Bright Futures Parent Handout

5 and 6 Year Visits

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

ORAL HEALTH

Healthy Teeth

- Help your child brush his teeth twice a day.
 - After breakfast
 - Before bed
- Use a pea-sized amount of toothpaste with fluoride.
- Help your child floss her teeth once a day.
- Your child should visit the dentist at least twice a year.

SCHOOL READINESS

Ready for School

- Take your child to see the school and meet the teacher.
- Read books with your child about starting school.
- Talk to your child about school.
- Make sure your child is in a safe place after school with an adult.
- Talk with your child every day about things he liked, any worries, and if anyone is being mean to him.
- Talk to us about your concerns.

MENTAL HEALTH

Your Child and Family

- Give your child chores to do and expect them to be done.
- Have family routines.
- Hug and praise your child.
- Teach your child what is right and what is wrong.
- Help your child to do things for herself.
- Children learn better from discipline than they do from punishment.
- Help your child deal with anger.
 - Teach your child to walk away when angry or go somewhere else to play.

NUTRITION AND PHYSICAL ACTIVITY

Staying Healthy

- Eat breakfast.
- Buy fat-free milk and low-fat dairy foods, and encourage 3 servings each day.
- Limit candy, soft drinks, and high-fat foods.
- Offer 5 servings of vegetables and fruits at meals and for snacks every day.
- Limit TV time to 2 hours a day.
- Do not have a TV in your child's bedroom.
- Make sure your child is active for 1 hour or more daily.

SAFETY

Safety

- Your child should always ride in the back seat and use a car safety seat or booster seat.
- Teach your child to swim.
- Watch your child around water.
- Use sunscreen when outside.
- Provide a good-fitting helmet and safety gear for biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Have a working smoke alarm on each floor of your house and a fire escape plan.
- Install a carbon monoxide detector in a hallway near every sleeping area.
- 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.
- Teach your child how to cross the street safely. Children are not ready to cross the street alone until age 10 or older.
- Teach your child about bus safety.
- Teach your child about how to be safe with other adults.
 - No one should ask for a secret to be kept from parents.
 - No one should ask to see private parts.
 - No adult should ask for help with his private parts.

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.



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						