



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: _____

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:	



Bright Futures Parent Supplemental Questionnaire

18 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.

Your Child and Family: Family Support

Do you take time for yourself?	Yes	No
Do you do activities as a family like playing together and eating meals together?	Yes	No
Do you know about community resources like WIC, Head Start, and food stamps?	Yes	No
Has your partner ever hurt you or your child?	No	Yes
Do you teach your child that behaviors like biting and hitting are not OK?	Yes	No
Does your child taste and try to eat new foods?	Yes	No
Are you considering having another child?	No	Yes
Do you have enough food for your family?	Yes	No

Your Child's Behavior: Child Development and Behavior

Do you play with and read to your child every day?	Yes	No
Do you praise your child for good behavior?	Yes	No
If your child is upset, do you help change his focus to another activity, book, or toy?	Yes	No
Do you talk to others about how to raise your child?	Yes	No
Do you and other caregivers set the same limits for your child?	Yes	No
How many hours per day does your child watch TV?	_____ hours	
Does your child play actively for at least one hour per day?	Yes	No

Talking and Hearing: Language Promotion/Hearing

Does your child point to what she wants, call some things by name, and wave bye-bye?	Yes	No
Do you read, sing, and talk with your child about what you are seeing and doing?	Yes	No
Do you use simple words to tell your child what to do?	Yes	No



Toilet Training: Toilet-training Readiness

Does your child show signs that he is ready to start toilet training?

Can stay dry for 2 hours	Yes	No
Knowing when he is wet and dry	Yes	No
Saying when he is about to have a bowel movement	Yes	No
Can pull his pants up and down	Yes	No
Do you read books with your child about using the potty?	Yes	No
Does your child go to the bathroom with a parent, brother, or sister to learn what to do?	Yes	No

Safety

Do you always use a car safety seat in the back seat of all vehicles?	Yes	No	
Are you having any problems with your car safety seat?	No	Yes	
Does everyone in the car always use a seat belt?	Yes	No	
Do you have smoke and carbon monoxide detectors on each floor of your home?	Yes	No	
In case of a fire, do you have a plan for getting everyone out of the house and a meeting place outside?	Yes	No	
Do you know the telephone number for poison control?	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 cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	Yes	No	
Do you keep your child away from the stove?	Yes	No	
Do you have a gate on your stairs?	Yes	No	
Do you keep furniture away from windows and use window guards for second floor and higher windows?	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?	N/A	Yes	No



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DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Bright Futures Medical Screening Questionnaire 18 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
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
Have your child's eyes ever been injured?	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



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18 Month Questionnaire

17 months 0 days
through 18 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 _____.

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 <i>point</i> 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

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.)

YES	SOMETIMES	NOT YET	___
<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"/>	___
-----------------------	-----------------------	-----------------------	-----

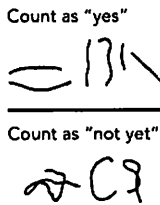
3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.)

<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"/>	___
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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"/>	___*
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PROBLEM SOLVING TOTAL

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

PERSONAL-SOCIAL

1. While looking at herself in the mirror, does your child offer a toy to her own image?

YES	SOMETIMES	NOT YET	___
<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

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

- | | | |
|--|-----|----|
| 1. Does your child enjoy being swung, bounced on your knee, etc.? | Yes | No |
| 2. Does your child take an interest in other children? | Yes | No |
| 3. Does your child like climbing on things, such as up stairs? | Yes | No |
| 4. Does your child enjoy playing peek-a-boo/hide-and-seek? | Yes | No |
| 5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things? | Yes | No |
| 6. Does your child ever use his/her index finger to point, to ask for something? | Yes | No |
| 7. Does your child ever use his/her index finger to point, to indicate interest in something? | Yes | No |
| 8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them? | Yes | No |
| 9. Does your child ever bring objects over to you (parent) to show you something? | Yes | No |
| 10. Does your child look you in the eye for more than a second or two? | Yes | No |
| 11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) | Yes | No |
| 12. Does your child smile in response to your face or your smile? | Yes | No |
| 13. Does your child imitate you? (e.g., you make a face-will your child imitate it?) | Yes | No |
| 14. Does your child respond to his/her name when you call? | Yes | No |
| 15. If you point at a toy across the room, does your child look at it? | Yes | No |
| 16. Does your child walk? | Yes | No |
| 17. Does your child look at things you are looking at? | Yes | No |
| 18. Does your child make unusual finger movements near his/her face? | Yes | No |
| 19. Does your child try to attract your attention to his/her own activity? | Yes | No |
| 20. Have you ever wondered if your child is deaf? | Yes | No |
| 21. Does your child understand what people say? | Yes | No |
| 22. Does your child sometimes stare at nothing or wander with no purpose? | Yes | No |
| 23. Does your child look at your face to check your reaction when faced with something unfamiliar? | Yes | No |



Bright Futures Parent Handout 18 Month Visit

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

LANGUAGE PROMOTION/HEARING

Talking and Hearing

- Read and sing to your child often.
- Talk about and describe pictures in books.
- Use simple words with your child.
- Tell your child the words for her feelings.
- Ask your child simple questions, confirm her answers, and explain simply.
- Use simple, clear words to tell your child what you want her to do.

Your Child and Family

- Create time for your family to be together.
- Keep outings with a toddler brief—1 hour or less.
- Do not expect a toddler to share.
- Give older children a safe place for toys they do not want to share.
- Teach your child not to hit, bite, or hurt other people or pets.
- Your child may go from trying to be independent to clinging; this is normal.
- Consider enrolling in a parent-toddler playgroup.
- Ask us for help in finding programs to help your family.
- Prepare for your new baby by reading books about being a big brother or sister.
- Spend time with each child.
- Make sure you are also taking care of yourself.
- Tell your child when he is doing a good job.
- Give your toddler many chances to try a new food. Allow mouthing and touching to learn about them.
- Tell us if you need help with getting enough food for your family.

FAMILY SUPPORT

SAFETY

Safety

- Use a car safety seat in the back seat of all vehicles.

SAFETY

- Read the instructions about your car safety seat to check on the weight and height requirements.
- Everyone should always 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.
- Move furniture away from windows.
- Watch your child closely when she is on the stairs.
- When backing out of the garage or driving in the driveway, have another adult hold your child a safe distance away so he is not run over.
- 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.
- Prevent burns by keeping hot liquids, matches, lighters, and the stove away from your child.
- Have a working smoke detector on every floor.

TOILET-TRAINING READINESS

Toilet Training

- Signs of being ready for toilet training include
 - Dry for 2 hours
 - Knows if he is wet or dry
 - Can pull pants down and up
 - Wants to learn
 - Can tell you if he is going to have a bowel movement
- Read books about toilet training with your child.

TOILET-TRAINING READINESS

CHILD DEVELOPMENT AND BEHAVIOR

- Have the parent of the same sex as your child or an older brother or sister take your child to the bathroom.
- Praise sitting on the potty or toilet even with clothes on.
- Take your child to choose underwear when he feels ready to do so.

Your Child's Behavior

- Set limits that are important to you and ask others to use them with your toddler.
- Be consistent with your toddler.
- Praise your child for behaving well.
- Play with your child each day by doing things she likes.
- Keep time-outs brief. Tell your child in simple words what she did wrong.
- Tell your child what to do in a nice way.
- Change your child's focus to another toy or activity if she becomes upset.
- Parenting class can help you understand your child's behavior and teach you what to do.
- Expect your child to cling to you in new situations.

What to Expect at Your Child's 2 Year Visit

We will talk about

- Your talking child
- Your child and TV
- Car and outside safety
- Toilet training
- How your child behaves

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.



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						