



# 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     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

## 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



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# 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



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# 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 \_\_\_\_\_.

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## 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?

                                                                 \_\_\_\_\_

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"/>	___
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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?



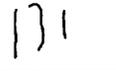
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

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)

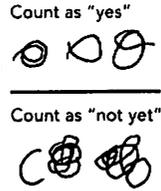
YES                      SOMETIMES                      NOT YET

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



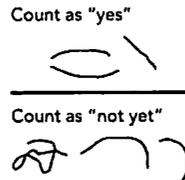
                                                                 \_\_\_\_\_

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](http://seatcheck.org)



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