ASQ-3 Ages & Stages Questionnaires®

12 Month Questionnaire

11 months 0 days through 12 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____

If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

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

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

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

Program name: _____

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Bright Futures Parent Supplemental Questionnaire 12 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.

Family Support

Do you need help teaching your child good behavior?	No	Yes
Do you reward your child's good behavior?	Yes	No
When your child misbehaves, do you use brief time-outs (1–2 minutes)?	Yes	No
Do you try to distract your child when she misbehaves?	Yes	No
Do you discuss your ideas about your child's behavior and discipline with your child's caregivers?	Yes	No
Do you participate in activities through social, religious, volunteer, or recreational programs?	Yes	No
Do you talk with friends about parenting?	Yes	No
Do you go to playgroups?	Yes	No

Establishing Routines

Do you play with and read to your child every day?	Yes	No
Do you help your child feel comfortable around new people?	Yes	No
Does your child have regular mealtimes and snack times?	Yes	No
Do you have a regular bedtime routine for your child?	Yes	No
Does your child play actively for one hour or more a day?	Yes	No
How many hours per day does your child watch TV?	_____ hours	

Feeding Your Child: Feeding and Appetite Changes

Do you give your child small, hard foods like peanuts or popcorn?	No	Yes
Do you give your child round foods such as hot dogs, raw carrots, or grapes?	No	Yes
Does your child try feeding himself using a spoon or fork?	Yes	No
Do you let your child decide what and how much to eat?	Yes	No

Finding a Dentist: Establishing a Dental Home

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

Safety

Do you always use a car safety seat rear-facing in the back seat of all vehicles?		Yes	No
Are you having any problems with your car safety seat?		No	Yes
Do you know when to turn your child's car safety seat forward?		Yes	No
Do you keep cleaners and medicines locked up?		Yes	No
Do you have a gate on your stairs?		Yes	No
Are you able to lock your windows?		Yes	No
Can your child climb out of her crib?		No	Yes
Is your child's crib on the lowest setting?		Yes	No
Do you stay within arm's reach when your child is in the bathtub?		Yes	No
Do you have a swimming pool, pond, or lake in or near your home?		No	Yes
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
Does anyone smoke around your child?		No	Yes
If you smoke, would you like information on how to stop?		Yes	No

Bright Futures Medical Screening Questionnaire
12 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 know a dentist to whom you can bring your child?	N	Y	Unsure
Does your child's primary water source contain fluoride?	N	Y	Unsure

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

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

ASQ-3™ 12 Month Questionnaire

11 months 0 days through 12 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your baby.
- ☑ Make sure your baby is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	___
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	○	○	○	___
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures?	○	○	○	___
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? *(A "word" is a sound or sounds your baby says consistently to mean someone or something.)*	○	○	○	___
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? *(Make sure the object is present. Mark "yes" if she knows one object.)*	○	○	○	___
6. When your baby wants something, does he tell you by *pointing* to it?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position? 	○	○	○	___
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	○	○	○	___
3. Does your baby walk beside furniture while holding on with only one hand?	○	○	○	___

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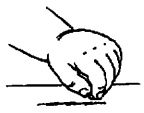
GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? *(If your baby already walks alone, mark "yes" for this item.)* 	○	○	○	___
5. When you hold *one hand* just to balance your baby, does she take several steps forward? *(If your baby already walks alone, mark "yes" for this item.)* 	○	○	○	___
6. Does your baby stand up in the middle of the floor by himself and take several steps forward?	○	○	○	___

GROSS MOTOR TOTAL ___

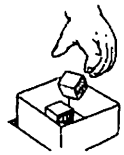
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? *(The string may be attached to a toy.)* 	○	○	○	___
2. Does your baby pick up a crumb or Cheerio with the *tips* of her thumb and a finger? She may rest her arm or hand on the table while doing it. 	○	○	○	___
3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?	○	○	○	___
4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the *tips* of her thumb and a finger? 	○	○	○	___ *
5. Does your baby throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)* 	○	○	○	___
6. Does your baby help turn the pages of a book? *(You may lift a page for him to grasp.)*	○	○	○	___

FINE MOTOR TOTAL ___

**If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	○	○	○	___
2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?	○	○	○	___
3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? *(Be sure the toy is completely hidden.)*	○	○	○	___
4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? *(If she already lets go of the toy into a bowl or box, mark "yes" for this item.)*	○	○	○	___
5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? *(You may show him how to do it.)* 	○	○	○	___ *
6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? *(If she already scribbles on her own, mark "yes" for this item.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? *(If he already lets go of the toy into your hand, mark "yes" for this item.)*	○	○	○	___
2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve?	○	○	○	___
3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand?	○	○	○	___
4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg?	○	○	○	___
5. Does your baby roll or throw a ball back to you so that you can return it to him?	○	○	○	___
6. Does your baby play with a doll or stuffed animal by hugging it?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain: ○ YES ○ NO

2. Does your baby play with sounds or seem to make words? If no, explain: ○ YES ○ NO

3. When your baby is standing, are her feet flat on the surface most of the time? If no, explain: ○ YES ○ NO

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain: ○ YES ○ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

6. Do you have concerns about your baby's vision? If yes, explain: ○ YES ○ NO

7. Has your baby had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

8. Do you have any concerns about your baby's behavior? If yes, explain: ○ YES ○ NO

9. Does anything about your baby worry you? If yes, explain: ○ YES ○ NO

Bright Futures Parent Handout
12 Month Visit

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

FAMILY SUPPORT

Family Support

- Try not to hit, spank, or yell at your child.
- Keep rules for your child short and simple.
- Use short time-outs when your child is behaving poorly.
- Praise your child for good behavior.
- Distract your child with something he likes during bad behavior.
- Play with and read to your child often.
- Make sure everyone who cares for your child gives healthy foods, avoids sweets, and uses the same rules for discipline.
- Make sure places your child stays are safe.
- Think about joining a toddler playgroup or taking a parenting class.
- Take time for yourself and your partner.
- Keep in contact with family and friends.

ESTABLISHING ROUTINES

Establishing Routines

- Your child should have at least one nap. Space it to make sure your child is tired for bed.
- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Avoid having your child watch TV and videos, and never watch anything scary.
- Be aware that fear of strangers is normal and peaks at this age.
- Respect your child's fears and have strangers approach slowly.
- Avoid watching TV during family time.
- Start family traditions such as reading or going for a walk together.

FEEDING AND APPETITE CHANGES

Feeding Your Child

- Have your child eat during family mealtime.
- Be patient with your child as she learns to eat without help.
- Encourage your child to feed herself.
- Give 3 meals and 2–3 snacks spaced evenly over the day to avoid tantrums.
- Make sure caregivers follow the same ideas and routines for feeding.
- Use a small plate and cup for eating and drinking.
- Provide healthy foods for meals and snacks.
- Let your child decide what and how much to eat.
- End the feeding when the child stops eating.
- Avoid small, hard foods that can cause choking—nuts, popcorn, hot dogs, grapes, and hard, raw veggies.

SAFETY

Safety

- It is best to keep your child's car safety seat rear-facing until she reaches the seat's weight or height limit for rear-facing use. Do not switch your child to a forward-facing car safety seat until she is at least 1 year old and weighs at least 20 pounds. Most children can ride rear-facing for much longer than 12 months.
- Lock away poisons, medications, and lawn and cleaning supplies. Call Poison Help (1-800-222-1222) if your child eats nonfoods.
- Keep small objects, balloons, and plastic bags away from your child.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher. Keep furniture away from windows.
- Lock away knives and scissors.

SAFETY

- Only leave your toddler with a mature adult.
- Near or in water, keep your child close enough to touch.
- Make sure to empty buckets, pools, and tubs when done.
- 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.

ESTABLISHING A DENTAL HOME

Finding a Dentist

- Take your child for a first dental visit by 12 months.
- Brush your child's teeth twice each day.
- With water only, use a soft toothbrush.
- If using a bottle, offer only water.

What to Expect at Your Child's 15 Month Visit

We will talk about

- Your child's speech and feelings
- Getting a good night's sleep
- Keeping your home safe for your child
- Temper tantrums and discipline
- Caring for your child's teeth

Poison Help: 1-800-222-1222

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

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Parents: Staff will complete the following pages.

ASQ-3™ 12 Month ASQ-3 Information Summary

11 months 0 days through 12 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	15.64		●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯	◯
Gross Motor	21.49		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Fine Motor	34.50		●	●	●	●	●	●	●	◯	◯	◯	◯	◯	◯
Problem Solving	27.32		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Personal-Social	21.73		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Uses both hands and both legs equally well? Yes **NO**
   Comments:
2. Plays with sounds or seems to make words? Yes **NO**
   Comments:
3. Feet are flat on the surface most of the time? Yes **NO**
   Comments:
4. Concerns about not making sounds? **YES** No
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the ▭ area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the ▨ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby'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						

P101120700

Laboratory Orders

Generations Primary Care
270 Burley Ave
Hopkinsville, KY 42240-8725
Phone: (270) 887-6767 Fax: (270) 887-6161

Patient Name:_____

Dob: _____ Date:_____

Please perform only the circled labs:

Hemoglobin/Hematocrit LC 005058 CPT 85014
Dx: Well child exam V20.2

Lead Level LC 042580 CPT 83655
Dx: Well child exam V20.2

_____	_____	_____
Kara Dixon, PA	Matt Smith, MD	Keith Toms, MD