



# Ages & Stages Questionnaires®

## 16 Month Questionnaire

15 months 0 days through 16 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: \_\_\_\_\_

Street address: \_\_\_\_\_ Relationship to child:  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

Child ID #:	Age at administration in months and days:
Program ID #:	If premature, adjusted age in months and days:
Program name:	



# 16 Month Questionnaire

15 months 0 days  
through 16 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:

- 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 \_\_\_\_\_.

### Notes:

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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. Does your child point to, pat, or try to pick up pictures in a book?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child say four or more words in addition to "Mama" and "Dada"?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When your child wants something, does she tell you by <i>pointing</i> to it?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. 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"/> | ___ |
| 5. 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"/> | ___ |
| 6. Does your child say eight or more words in addition to "Mama" and "Dada"?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

COMMUNICATION TOTAL

\_\_\_

## GROSS MOTOR

YES                      SOMETIMES                      NOT YET

- |  |                       |                       |                       |     |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your child stand up in the middle of the floor by himself and take several steps forward?                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child climb onto furniture or other large objects, such as large climbing blocks?                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. 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"/> | ___ |

**GROSS MOTOR** (continued)

	YES	SOMETIMES	NOT YET	
4. Does your child move around by walking, rather than crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. 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"/>	___
<b>GROSS MOTOR TOTAL</b>				___

**FINE MOTOR**

	YES	SOMETIMES	NOT YET	
1. Does your child help turn the pages of a book? (You may lift a page for her to grasp.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. 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"/>	___
3. 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"/>	___
4. Does your child stack three small blocks or toys on top of each other by herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. 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"/>	___
6. 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"/>	___
<b>FINE MOTOR TOTAL</b>				___

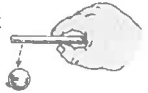


**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET	
1. After you scribble back and forth on paper with a crayon (or pencil or pen), does your child copy you by scribbling? (If she already scribbles on her own, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

**PROBLEM SOLVING** (continued)

YES                      SOMETIMES                      NOT YET                      \_\_\_\_\_

4. 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? 

                                                                 \_\_\_\_\_

5. Without your showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)?

                                                                 \_\_\_\_\_\*

6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump it out? (You may show her how.)

                                                                 \_\_\_\_\_

PROBLEM SOLVING TOTAL \_\_\_\_\_

*\*If Problem Solving Item 5 is marked "yes," mark Problem Solving Item 1 as "yes."*

**PERSONAL-SOCIAL**

YES                      SOMETIMES                      NOT YET                      \_\_\_\_\_

1. Does your child feed himself with a spoon, even though he may spill some food?

                                                                 \_\_\_\_\_

2. Does your child help undress herself by taking off clothes like socks, hat, shoes, or mittens?

                                                                 \_\_\_\_\_

3. Does your child play with a doll or stuffed animal by hugging it?

                                                                 \_\_\_\_\_

4. While looking at himself in the mirror, does your child offer a toy to his own image?

                                                                 \_\_\_\_\_

5. Does your child get your attention or try to show you something by pulling on your hand or clothes?

                                                                 \_\_\_\_\_

6. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?

                                                                 \_\_\_\_\_

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

**OVERALL** (continued)

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

7. Has your child had any medical problems in the last several months? If yes, explain:

 YES NO

**OVERALL** (continued)

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



# 16 Month ASQ-3 Information Summary

15 months 0 days through  
16 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	16.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	37.91		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	31.98		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	30.51		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	26.43		●	●	●	●	●	○	○	○	○	○	○	○	○

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

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