



# Ages & Stages Questionnaires®

## 30 Month Questionnaire

28 months 16 days through 31 months 15 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: \_\_\_\_\_

Child's gender:  Male  Female

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP/Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

#### Relationship to child:

- Parent     Guardian     Teacher     Child care provider  
 Grandparent or other relative     Foster parent     Other: \_\_\_\_\_

Names of people assisting in questionnaire completion: \_\_\_\_\_

### Program information

Child ID #: \_\_\_\_\_

Program ID #: \_\_\_\_\_

Program name: \_\_\_\_\_



# 30 Month Questionnaire

28 months 16 days  
through 31 months 15 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:

---



---



---



---

## COMMUNICATION

- |   | YES                   | SOMETIMES             | NOT YET               |     |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly name at least one picture?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Without your giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <input type="radio"/> a. "Put the toy on the table." <input type="radio"/> d. "Find your coat."<br><input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand."<br><input type="radio"/> c. "Bring me a towel." <input type="radio"/> f. "Get your book."                  |                       |                       |                       |     |
| 3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least <i>seven</i> body parts? (She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least <i>three</i> different body parts.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child make sentences that are three or four words long? Please give 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>  |                       |                       |                       |     |
| 5. 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?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. 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?"  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

COMMUNICATION TOTAL \_\_\_\_\_

**GROSS MOTOR**

YES                      SOMETIMES                      NOT YET

1. Does your child run fairly well, stopping herself without bumping into things or falling?



                                                                 \_\_\_\_\_

2. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)



                                                                 \_\_\_\_\_

3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?



                                                                 \_\_\_\_\_

4. Does your child jump with both feet leaving the floor at the same time?



                                                                 \_\_\_\_\_

5. 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.



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

6. Does your child stand on one foot for about 1 second without holding onto anything?










                                                                 \_\_\_\_\_

**GROSS MOTOR TOTAL**

\_\_\_\_\_


*\*If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

**FINE MOTOR**

- |   | YES   | SOMETIMES             | NOT YET               |   |
|---|---|-----------------------|-----------------------|---|
| 1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |
| 2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him 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? | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |
|   | <p style="text-align: center;">Count as "yes" </p> <p style="text-align: center;">Count as "not yet" </p>     |                       |                       |   |
| 3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |
|   |    |                       |                       |   |
| 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?                        | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |
|   | <p style="text-align: center;">Count as "yes" </p> <p style="text-align: center;">Count as "not yet" </p>     |                       |                       |   |
| 5. 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?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |
|   | <p style="text-align: center;">Count as "yes" </p> <p style="text-align: center;">Count as "not yet" </p> |                       |                       |   |
| 6. Does your child turn pages in a book, one page at a time?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |

FINE MOTOR TOTAL —

**PROBLEM SOLVING**

- |   | YES   | SOMETIMES             | NOT YET               |   |
|---|---|-----------------------|-----------------------|---|
| 1. When looking in the mirror, ask, "Where is _____?" (Use your child's name.) Does your child point to her image in the mirror?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |
|   |  |                       |                       |   |
| 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)? | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | — |

**PROBLEM SOLVING** (continued)

YES                      SOMETIMES                      NOT YET

3. 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.)



                                                                 \_\_\_\_\_

4. 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:



                                                                 \_\_\_\_\_

5. 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.
6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? (You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)

                                                                 \_\_\_\_\_

                                                                 \_\_\_\_\_

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

**PERSONAL-SOCIAL**

YES                      SOMETIMES                      NOT YET

1. If you do any of the following gestures, does your child copy at least one of them?

                                                                 \_\_\_\_\_

- a. Open and close your mouth.                       c. Pull on your earlobe.  
 b. Blink your eyes.                       d. Pat your cheek.

2. Does your child use a spoon to feed himself with little spilling?
3. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?
4. Does your child put on a coat, jacket, or shirt by himself?
5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?
6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?

                                                                 \_\_\_\_\_

                                                                 \_\_\_\_\_

                                                                 \_\_\_\_\_

                                                                 \_\_\_\_\_

                                                                 \_\_\_\_\_

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 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 toddlers 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



# 30 Month ASQ-3 Information Summary

28 months 16 days through  
31 months 15 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	33.30		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	36.14		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	19.25		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	27.08		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	32.01		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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. Family history of hearing impairment?<br>Comments: | <b>YES</b> | No |
| 2. Talks like other toddlers his age?<br>Comments:              | Yes | <b>NO</b> | 7. Concerns about vision?<br>Comments:                | <b>YES</b> | No |
| 3. Understand most of what your child says?<br>Comments:        | Yes | <b>NO</b> | 8. Any medical problems?<br>Comments:                 | <b>YES</b> | No |
| 4. Others understand most of what your child says?<br>Comments: | Yes | <b>NO</b> | 9. Concerns about behavior?<br>Comments:              | <b>YES</b> | No |
| 5. Walks, runs, and climbs like other toddlers?<br>Comments:    | Yes | <b>NO</b> | 10. Other concerns?<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						