12 Month • 1 Year Questionnaire

Please provide the following information.

Child's name: ____________________________________________

Child's date of birth: ______________________________________

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

______________________________

Today's date: ____________________________________________

Please complete this questionnaire on or before: _______________

Person filling out this questionnaire: ____________________________

What is your relationship to the child? _______________________

Your telephone: ____________________________________________

Your mailing address: ________________________________________

___________________________________________________________

City: ______________________________________________________

State: _____________________________________________________ zip code: __________

List people assisting in questionnaire completion:

____________________________________________________________________

____________________________________________________________________

Administering program or provider: ____________________________

ASQ
COMMUNICATION

1. If you ask her to, does your baby play at least one nursery game even if you don't show her the activity yourself (e.g., "bye-bye," "Peekaboo," "clap your hands," "So Big")?

2. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?

3. Does your baby say one word in addition to "Mama" and "Dada"? (A "word" is a sound or sounds the baby says consistently to mean someone or something, such as "baba" for bottle.)

4. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? Make sure the object is present. Check "yes" if he knows one object.

5. When your baby wants something, does she tell you by pointing to it?

6. Does your baby shake his head when he means "no" or "yes"?

COMMUNICATION TOTAL

GROSS MOTOR

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 along furniture while holding on with only one hand?

4. If you hold both hands just to balance him, does your baby take several steps without tripping or falling? (If your baby already walks alone, check "yes" for this item.)

5. When you hold one hand just to balance her, does your baby take several steps forward? (If your baby already walks alone, check "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  

Be sure to try each activity with your child.

1. After one or two tries, does your baby pick up a piece of string with her 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 his thumb and a finger? He may rest his arm or hand on the table while doing it.

3. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?

4. Without resting his arm or hand on the table, does your baby pick up a crumb or Cheerio with the tip of his thumb and a finger?

5. Does your baby throw a small ball with a forward arm motion? (If he simply drops the ball, check "not yet" for this item.)

6. Does your baby help turn the pages of a book? (You may lift a page for her to grasp.)

FINE MOTOR TOTAL

PROBLEM SOLVING  

Be sure to try each activity with your child.

1. While 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 he watches 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, check "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.)

* If fine motor item 4 is marked "yes" or "sometimes," mark fine motor item 2 as "yes."
PROBLEM SOLVING

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, check "yes" for this item.)

■ YES ■ SOMETIMES ■ NOT YET

PROBLEM SOLVING TOTAL

*If problem solving item 5 is marked "yes" or "sometimes," mark problem solving item 4 as "yes."

PERSONAL-SOCIAL

Be sure to try each activity with your child.

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, check "yes" for this item.)

■ YES ■ SOMETIMES ■ NOT YET

2. When you dress her, does your baby push her arm through a sleeve once her arm is started in the hole of the sleeve?

■ YES ■ SOMETIMES ■ NOT YET

3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand?

■ YES ■ SOMETIMES ■ NOT YET

4. When you dress her, does your baby lift her foot for her shoe, sock, or pant leg?

■ YES ■ SOMETIMES ■ NOT YET

5. Does your baby roll or throw a ball back to you so that you can return it to him?

■ YES ■ SOMETIMES ■ NOT YET

6. Does your baby play with a doll or stuffed animal by hugging it?

■ YES ■ SOMETIMES ■ NOT YET

PERSONAL-SOCIAL TOTAL

OVERALL

Parents and providers may use the back of this sheet for additional comments.

1. Do you think your child hears well?
   If no, explain: ____________________________

■ YES ■ NO

2. Does your baby use both hands equally well?
   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. Does either parent have a family history of childhood deafness or hearing impairment?
   If yes, explain: ____________________________

■ YES ■ NO

5. Do you have concerns about your child's vision?
   If yes, explain: ____________________________

■ YES ■ NO

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

■ YES ■ NO

7. Does anything about your child worry you?
   If yes, explain: ____________________________

■ YES ■ NO
12 Month/1 Year ASQ Information Summary

Child's name: ____________________________  Date of birth: ____________________________
Person filling out the ASQ: ____________________________  Corrected date of birth: ____________________________
Mailing address: ____________________________  Relationship to child: ____________________________
Telephone: ____________________________  City: ____________________________ State: ____________________________ zip: ____________________________
Today's date: ____________________________  Assisting in ASQ completion: ____________________________

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1. Hears well?  Comments:
   YES NO
2. Uses both hands equally well?  Comments:
   YES NO
3. Baby's feet flat on the surface?  Comments:
   YES NO
4. Family history of hearing impairment?  Comments:
   YES NO
5. Vision okay?  Comments:
   YES NO
6. Recent medical problems?  Comments:
   YES NO
7. Other concerns?  Comments:
   YES NO

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in The ASQ User's Guide.
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10   SOMETIMES = 5   NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.

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<th>Total</th>
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<th>10</th>
<th>15</th>
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</tbody>
</table>

Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

<table>
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Administering program or provider:

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