

Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System
Second Edition

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

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24 Month • 2 Year

Questionnaire



On the following pages are questions about activities children 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 check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Be sure to try each activity with your child before checking a box.
- Try to make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested, fed, and ready to play.
- Please return this questionnaire by _____.
- If you have any questions or concerns about your child or about this questionnaire, please call: _____.
- Look forward to filling out another questionnaire in _____ months.



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24 Month • 2 Year Questionnaire

Please provide the following information.

Child's name: _____

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: _____



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, score "yes" for the item.

YES SOMETIMES NOT YET

COMMUNICATION *Be sure to try each activity with your child.*

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-------|
| 1. Without showing her first, does your child <i>point</i> to the correct picture when you say, "Show me the kitty" or ask, "Where is the dog?" (She needs to identify only one picture correctly.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. 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? (Check "yes" even if his words are difficult to understand.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Without giving her clues by pointing or using gestures, can your child carry out at least <i>three</i> of these kinds of directions?
a. "Put the toy on the table." d. "Find your coat."
b. "Close the door." e. "Take my hand."
c. "Bring me a towel." f. "Get your book." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly <i>name</i> at least one picture? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "Bye-bye," "All gone," "All right," and "What's that?")

Please give an example of your child's word combinations:

_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Does your child correctly use at least two words like "me," "I," "mine," and "you"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

COMMUNICATION TOTAL _____



GROSS MOTOR *Be sure to try each activity with your child.*

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-------|
| 1. Does your child walk down stairs if you hold onto one of his hands? (You can look for this at a store, on a playground, or at home.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. When you show her how to kick a large ball, does your child try to kick the ball by moving her leg forward or by walking into it? (If your child already kicks a ball, check "yes" for this item.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Does your child walk either up or down at least two steps by himself? You can look for this at a store, on a playground, or at home. (Check "yes" even if he holds onto the wall or railing.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Does your child run fairly well, stopping herself without bumping into things or falling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |



YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

- | | | | | | |
|--|---|--------------------------|--------------------------|--------------------------|---------|
| 5. Does your child jump with both feet leaving the floor at the same time? |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ * |

GROSS MOTOR TOTAL _____

**If gross motor item 6 is marked "yes" or "sometimes," mark gross motor item 2 as "yes."*

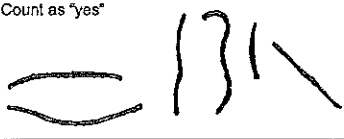
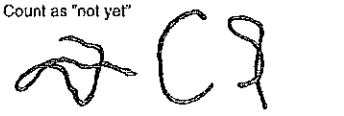
FINE MOTOR *Be sure to try each activity with your child.*

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-------|
| 1. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Does your child flip switches off and on? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Does your child stack seven small blocks or toys on top of each other by himself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Does your child thread a shoelace through either a bead or an eyelet of a shoe? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |



FINE MOTOR TOTAL _____

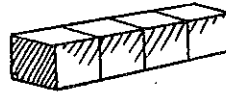
PROBLEM SOLVING *Be sure to try each activity with your child.*

- | | | | | | |
|--|---|--------------------------|--------------------------|--------------------------|-------|
| 1. After she watches you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in <i>any direction</i> ? (Scribbling back and forth does not count as "yes.") | <p>Count as "yes"</p>  <hr/> <p>Count as "not yet"</p>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Without showing him how, does your child purposefully turn a small, clear bottle upside down to dump out a crumb or Cheerio? (You can use a soda-pop bottle or baby bottle.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |

YES SOMETIMES NOT YET

PROBLEM SOLVING *(continued)*

- 3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food? _____
- 4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen? _____
- 5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it? _____
- 6. 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.) _____



PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

- 1. Does your child drink from a cup or glass, putting it down again with little spilling? _____
- 2. Does your child copy activities you do, such as wipe up a spill, sweep, shave, or comb hair? _____
- 3. Does your child eat with a fork? _____
- 4. When playing with either a stuffed animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth? _____
- 5. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if he cannot turn? _____
- 6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it." _____

PERSONAL-SOCIAL TOTAL _____

OVERALL *Parents and providers may use the space at the bottom of the next sheet for additional comments.*

- 1. Do you think your child hears well? YES NO
If no, explain: _____
- 2. Do you think your child talks like other toddlers her age? YES NO
If no, explain: _____

OVERALL (continued)

3. Can you understand most of what your child says? YES NO
If no, explain: _____
4. Do you think your child walks, runs, and climbs like other toddlers his age? YES NO
If no, explain: _____
5. Does either parent have a family history of childhood deafness or hearing impairment? YES NO
If yes, explain: _____
6. Do you have any concerns about your child's vision? YES NO
If yes, explain: _____
7. Has your child had any medical problems in the last several months? YES NO
If yes, explain: _____
8. Does anything about your child worry you? YES NO
If yes, explain: _____

24 Month/2 Year ASQ Information Summary

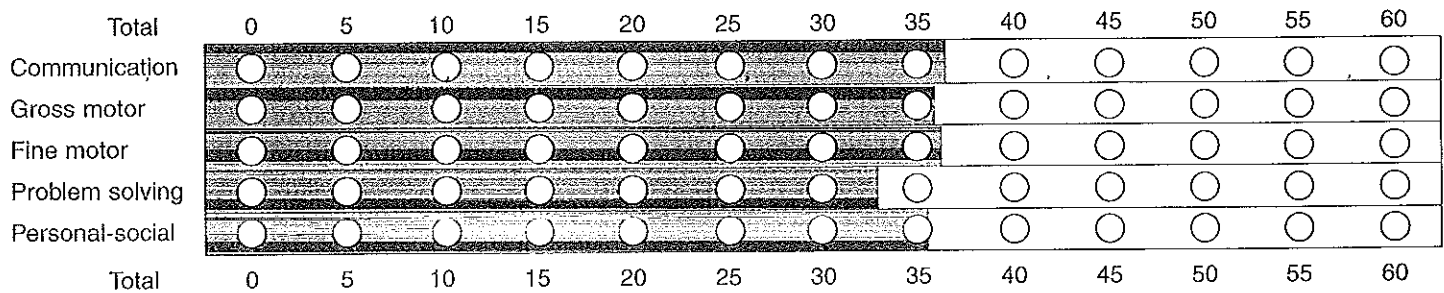
Child's name: _____ Date of birth: _____
 Person filling out the ASQ: _____ Relationship to child: _____
 Mailing address: _____ City: _____ State: _____ ZIP: _____
 Telephone: _____ Assisting in ASQ completion: _____
 Today's date: _____

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 | 5. Family history of hearing impairment?
Comments: | YES NO |
| 2. Talks like other toddlers?
Comments: | YES NO | 6. Vision okay?
Comments: | YES NO |
| 3. Understand child?
Comments: | YES NO | 7. Recent medical problems?
Comments: | YES NO |
| 4. Walks, runs, and climbs like others?
Comments: | YES NO | 8. Other concerns?
Comments: | YES NO |

SCORING THE QUESTIONNAIRE

- 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*.
- 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
- Add up the item scores for each area, and record these totals in the space provided for area totals.
- 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.



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

- If the child's total score falls within the area, the child appears to be doing well in this area at this time.
- 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.

	Score	Cutoff	Communication			Gross motor			Fine motor			Problem solving			Personal-social		
			1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
24 months/2 years																	
Communication		36.5															
Gross motor		36.0															
Fine motor		36.4															
Problem solving		32.9															
Personal-social		35.6															
			Y	S	N	Y	S	N	Y	S	N	Y	S	N	Y	S	N

Administering program or provider: _____

Faint, illegible text scattered across the top portion of the page, possibly representing a header or introductory paragraph.

The majority of the page is filled with extremely faint and illegible text, which appears to be the main body of a document. The text is too light to be accurately transcribed.