

YES      SOMETIMES      NOT YET

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

- |  |                          |                          |                            |   |
|--|--------------------------|--------------------------|----------------------------|---|
| 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")?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | — |
| 2. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," <i>without</i> your using gestures?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | — |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | — |
| 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.                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | — |
| 5. When your baby wants something, does she tell you by <i>pointing</i> to it?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | — |
| 6. Does your baby shake his head when he means "no" or "yes"?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | — |
|  |                          |                          | <b>COMMUNICATION TOTAL</b> | — |

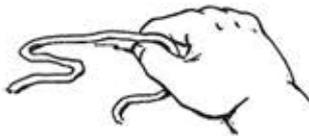
**GROSS MOTOR**      *Be sure to try each activity with your child.*

- |  |   |                          |                          |                          |   |
|--|---|--------------------------|--------------------------|--------------------------|---|
| 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?   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 3. Does your baby walk along furniture while holding on with only one hand?  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 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.) |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 5. When you hold <i>one hand</i> just to balance her, does your baby take several steps forward? (If your baby already walks alone, check "yes" for this item.)              |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 6. Does your baby stand up in the middle of the floor by himself and take several steps forward?   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
|  |   |                          | <b>GROSS MOTOR TOTAL</b> | —                        |   |

YES      SOMETIMES      NOT YET

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

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

**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.)



                 \_\_\_\_\_\*



# 12 Month/1 Year ASQ Information Summary

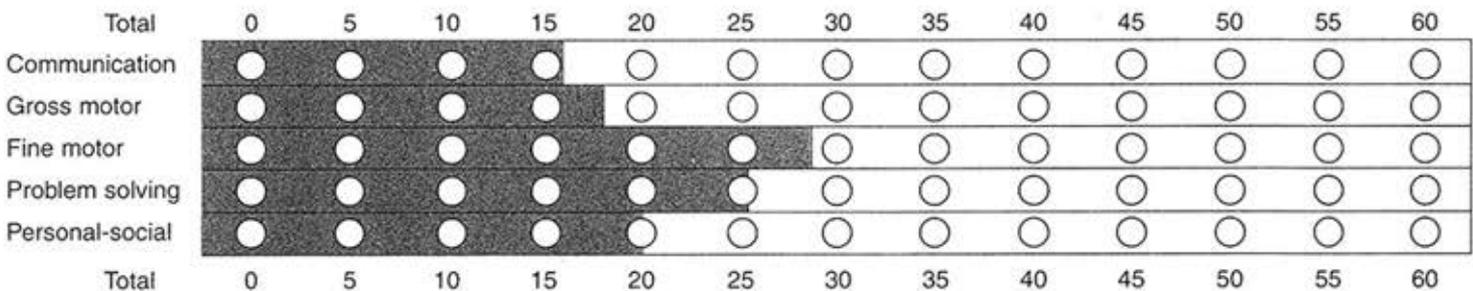
Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Person filling out the ASQ: \_\_\_\_\_ Corrected date of birth: \_\_\_\_\_  
 Mailing address: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Today's date: \_\_\_\_\_ Assisting 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?<br>Comments:                      | YES NO | 4. Family history of hearing impairment?<br>Comments: | YES NO |
| 2. Uses both hands equally well?<br>Comments:    | YES NO | 5. Vision okay?<br>Comments:                          | YES NO |
| 3. Baby's feet flat on the surface?<br>Comments: | YES NO | 6. Recent medical problems?<br>Comments:              | YES NO |
|  |        | 7. Other concerns?<br>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.  
 1. 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.

12 months/1 year	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
Communication		15.8	<input type="radio"/>														
Gross motor		18.0	<input type="radio"/>														
Fine motor		28.4	<input type="radio"/>														
Problem solving		25.2	<input type="radio"/>														
Personal-social		20.1	<input type="radio"/>														
			Y	S	N	Y	S	N	Y	S	N	Y	S	N	Y	S	N

Administering program or provider: \_\_\_\_\_