Rainbow Children's Clinic

(18-35 MONTHS)

Name: _____ **D.O.B:** _____ **Today's Date:** _____

MCHAT

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer no. Please circle yes or no for every question. Thank You.

1.	YES	NO	If you point at something across the room, does your child look at it? (For example, if you point at a toy or an animal, does your child look at the toy or animal? When you say, "Look" by pointing to something does your child look at it too?)
2.	YES	NO	Have you ever wondered if your child might be deaf?
3.	YES	NO	Does your child play pretend or make-believe? (For example, pretend to drink milk from from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)
4.	YES	NO	Does your child like climbing on things? (For example, furniture, playground equipment, or stairs)
5.	YES	NO	Does your child make unusual (ABNORMAL, not playing) finger movements near his or her eyes? (For example, does your child wiggle his or her fingers close to his or her eyes?)
6.	YES	NO	Does your child point with one finger to ask for something or to get help? (For example, pointing to a snack or toy that is out of reach).
7.	YES	NO	Does your child point with one finger to show you something interesting? (For example, pointing to an airplane in the sky or a big truck in the road, or a cartoon character while watching).
8.	YES	NO	Is your child interested in other children? (For example, does your child watch other children, smile at them, or go to them?)
9.	YES	NO	Does your child show you things by bringing them to you or holding them up for you to see not to get help, but just to share? (For example, showing you a flower, a stuffed animal, or a toy truck).
10.	YES	NO	Does your child respond when you call his or her name? (For example, does he or she look up, Talk or babble, or stop what he or she is doing when you call his or her name?)
11.	YES	NO	When you smile at your child, does he or she smile back at you?
12.	YES	NO	Does your child get very upset (ABNORALLY) by everyday noise? (For example, does your child scream or excessively cry to noise such as a vacuum cleaner, or loud music?)
13.	YES	NO	Does your child walk?
14.	YES	NO	Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?
15.	YES	NO	Does your child try to copy what you do? (For example, wave bye-bye, clap, or make funny noise when you do?)
16.	YES	NO	If you turn your head to look at something, does your child look around to see what you are looking at? (For example, a picture on the wall, a phone, or somebody).
17.	YES	NO	Does your child try to get you to watch him or her? (For example, does your child look to you for Praise, or say "look" or "watch me"?)
18.	YES	NO	Does your child understand when you tell him or her to do something? (For example, if you don't point, can your child understand "put the book down," bring me the blanket, my phone, cup, or bottle. Does it look like they are trying to understand?
19.	YES	NO	If something new happens, does your child look at your face to see how you feel about it? (For example, if he or she hears a strange or funny noise, or drops something, or sees a new toy will he or she look at your face?)
20.	YES	NO	Does your child like movement activities? (For example, being swung or bounced on your knee).

****Slightly revised to avoid confusion for question 5 & 12**

CLINIC USE ONLY

____**No risk factors** ____**Positive risk factors**

____**M-CHAT R/F completed** ____**Referral for evaluation**

Reviewed By: _____

ASQ-3 Ages & Stages Questionnaires®

28 months 16 days through 31 months 15 days

30 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

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 #:

Program ID #:

Program name:

E101300100

ASQ-3

30 Month Questionnaire

28 months 16 days through 31 months 15 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby 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?	○	○	○	___
2. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* 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."				
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 *seven* body parts? *(She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)*	○	○	○	___
4. Does your child make sentences that are three or four words long? Please give an example:	○	○	○	___
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?	○	○	○	___
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?"	○	○	○	___

COMMUNICATION TOTAL ___

E101300200

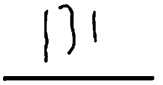
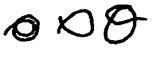
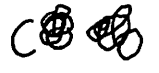
GROSS MOTOR

		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

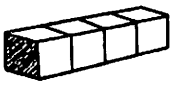
	YES	SOMETIMES	NOT YET	
1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	○	○	○	___
2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to 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? Count as "yes"  Count as "not yet" 	○	○	○	___
3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	___
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? Count as "yes"  Count as "not yet" 	○	○	○	___
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? Count as "yes"  Count as "not yet" 	○	○	○	___
6. Does your child turn pages in a book, one page at a time?	○	○	○	___

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? 	○	○	○	___
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)?	○	○	○	___

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

ASQ-3 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		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.14		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	19.25		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	27.08		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	32.01		●	●	●	●	●	●	●	○	○	○	○	○	○

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

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

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						

P101300800