



# Ages & Stages Questionnaires®

## 27 Month Questionnaire

25 months 16 days through 28 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 gender:  
 Male  Female

Child's date of birth: \_\_\_\_\_

### Person filling out questionnaire

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

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

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

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:	_____



# 27 Month Questionnaire

25 months 16 days  
through 28 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:

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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, mark "yes" for the item.

## COMMUNICATION

- |   | YES                   | SOMETIMES             | NOT YET               | _____ |
|---|-----------------------|-----------------------|-----------------------|-------|
| 1. 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."                    |                       |                       |                       |       |
| 2. 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="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least <i>seven</i> body parts? ( <i>She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.</i> ) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. Does your child correctly use at least two words like "me," "I," "mine," and "you"?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Does your child make sentences that are three or four words long?<br>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>  |                       |                       |                       |       |
| 6. Without giving your child help by pointing or using gestures, ask him to "put the book <i>on</i> the table" and "put the shoe <i>under</i> the chair." Does your child carry out both of these directions correctly?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |

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

**GROSS MOTOR**

YES                      SOMETIMES                      NOT YET

1. 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.)



                                                                 \_\_\_\_\_

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



                                                                 \_\_\_\_\_

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



                                                                 \_\_\_\_\_

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



                                                                 \_\_\_\_\_

5. Does your child jump forward at least 3 inches with both feet leaving the ground at the same time?



                                                                 \_\_\_\_\_

6. 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.




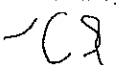

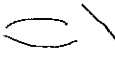

                                                                 \_\_\_\_\_\*

GROSS MOTOR TOTAL

\_\_\_\_\_

\*If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 1 "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. Does your child flip switches off and on?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. 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"/> | — |
| <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div>     |                       |                       |                       |   |
| 4. Does your child stack seven small blocks or toys on top of each other by herself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. 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"/> | — |
|    |                       |                       |                       |   |
| 6. 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"/> | — |
| <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Count as "yes"</p>  </div> <div style="text-align: center;"> <p>Count as "not yet"</p>  </div> </div> |                       |                       |                       |   |

FINE MOTOR TOTAL —

## PROBLEM SOLVING

- |  | YES                   | SOMETIMES             | NOT YET               |   |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child pretend objects are something else? For example, does your child hold a cup to his ear, pretending it is a telephone? Does he put a box on her head, pretending it is a hat? Does he use a block or small toy to stir food? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child put things away where they belong? For example, does she know her toys belong on the toy shelf, her blanket goes on her bed, and dishes go in the kitchen?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. When looking in the mirror, ask "Where is _____?" (Use your child's name.) Does your child point to his image in the mirror?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. If your child wants something she cannot reach, does she 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                      \_\_\_\_\_

5. 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.)



                                                                 \_\_\_\_\_

6. 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:



                                                                 \_\_\_\_\_

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 eat with a fork?

                                                                 \_\_\_\_\_

3. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?

                                                                 \_\_\_\_\_

4. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?

                                                                 \_\_\_\_\_

5. 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."

                                                                 \_\_\_\_\_

6. Does your child put on a coat, jacket, or shirt by himself?

                                                                 \_\_\_\_\_

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. Do you think your child walks, runs, and climbs like other toddlers his age?  
If no, explain:

YES

NO

5. Does either parent have a family history of childhood deafness or hearing  
impairment? If yes, explain:

YES

NO

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

YES

NO

**OVERALL** (continued)

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

YES

NO

8. Do you have any concerns about your child's behavior? If yes, explain:

YES

NO

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

YES

NO



Child's name \_\_\_\_\_  
Age \_\_\_\_\_

Date \_\_\_\_\_  
Relationship to child \_\_\_\_\_

**M-CHAT-R™** (Modified Checklist for Autism in Toddlers Revised)

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 very much.

- |   |     |    |
|---|-----|----|
| 1. If you point at something across the room, does your child look at it?<br>(FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)  | Yes | No |
| 2. Have you ever wondered if your child might be deaf?  | Yes | No |
| 3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)                                      | Yes | No |
| 4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)   | Yes | No |
| 5. Does your child make <u>unusual</u> finger movements near his or her eyes?<br>(FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)   | Yes | No |
| 6. Does your child point with one finger to ask for something or to get help?<br>(FOR EXAMPLE, pointing to a snack or toy that is out of reach)   | Yes | No |
| 7. Does your child point with one finger to show you something interesting?<br>(FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)   | Yes | No |
| 8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)   | Yes | No |
| 9. 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)          | Yes | No |
| 10. 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?)                                  | Yes | No |
| 11. When you smile at your child, does he or she smile back at you?   | Yes | No |
| 12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?)   | Yes | No |
| 13. Does your child walk?   | Yes | No |
| 14. 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?  | Yes | No |
| 15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)   | Yes | No |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at?   | Yes | No |
| 17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?)   | Yes | No |
| 18. Does your child understand when you tell him or her to do something?<br>(FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)                   | Yes | No |
| 19. If something new happens, does your child look at your face to see how you feel about it?<br>(FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) | Yes | No |
| 20. Does your child like movement activities?<br>(FOR EXAMPLE, being swung or bounced on your knee)   | Yes | No |



# Office Use Only



## 27 Month ASQ-3 Information Summary

25 months 16 days through  
28 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	24.02		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	28.01		●	●	●	●	●	●	○	○	○	○	○	○	○
Fine Motor	18.42		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	27.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	25.31		●	●	●	●	●	○	○	○	○	○	○	○	○

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