



# Ages & Stages Questionnaires®

## 12 Month Questionnaire

11 months 0 days through 12 months 30 days



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

Date ASQ completed: \_\_\_\_\_

### Baby's information

Baby's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Baby's last name: \_\_\_\_\_

Baby's date of birth: \_\_\_\_\_ If baby was born 3 or more weeks prematurely, # of weeks premature: \_\_\_\_\_

Baby's gender:  Male  Female

### Person filling out questionnaire

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

Street address: \_\_\_\_\_ Relationship to baby:  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

Baby ID #: \_\_\_\_\_ Age at administration in months and days: \_\_\_\_\_

Program ID #: \_\_\_\_\_ If premature, adjusted age in months and days: \_\_\_\_\_

Program name: \_\_\_\_\_



# 12 Month Questionnaire

11 months 0 days  
through 12 months 30 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:

### Notes:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by \_\_\_\_\_.

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## COMMUNICATION



	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peek-a-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? (Make sure the object is present. Mark "yes" if she knows one object.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. When your baby wants something, does he tell you by pointing to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				COMMUNICATION TOTAL ___

## GROSS MOTOR





	YES	SOMETIMES	NOT YET	
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="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



**GROSS MOTOR** (continued)

	YES	SOMETIMES	NOT YET	
4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. When you hold one hand just to balance your baby, does she take several steps forward? (If your baby already walks alone, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby stand up in the middle of the floor by himself and take several steps forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				GROSS MOTOR TOTAL ___

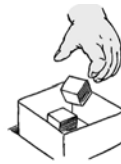
**FINE MOTOR**

	YES	SOMETIMES	NOT YET	
1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? (The string may be attached to a toy.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger? She may rest her arm or hand on the table while doing it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the tips of her thumb and a finger?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ *
				
5. Does your baby throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby help turn the pages of a book? (You may lift a page for him to grasp.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				FINE MOTOR TOTAL ___

\*If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

## PROBLEM SOLVING

- |  | YES                   | SOMETIMES             | NOT YET               |       |
|--|-----------------------|-----------------------|-----------------------|-------|
| 1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
| 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)?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
| 3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? <i>(Be sure the toy is completely hidden.)</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
| 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? <i>(If she already lets go of the toy into a bowl or box, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |
| 5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? <i>(You may show him how to do it.)</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ * |
| 6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? <i>(If she already scribbles on her own, mark "yes" for this item.)</i>                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___   |



PROBLEM SOLVING TOTAL

*\*If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."*

## PERSONAL-SOCIAL

- |   | YES                   | SOMETIMES             | NOT YET               |     |
|---|-----------------------|-----------------------|-----------------------|-----|
| 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? <i>(If he already lets go of the toy into your hand, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby roll or throw a ball back to you so that you can return it to him?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your baby play with a doll or stuffed animal by hugging it?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

PERSONAL-SOCIAL TOTAL

**OVERALL**

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. Does your baby play with sounds or seem to make words? 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. Do you have concerns that your baby is too quiet or does not make sounds like  
other babies do? If yes, explain:

YES

NO

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

YES

NO

**OVERALL** (continued)

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

 YES NO

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

 YES NO

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

 YES NO

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

 YES NO



# 12 Month ASQ-3 Information Summary

11 months 0 days through  
12 months 30 days

Baby's name: \_\_\_\_\_ Date ASQ completed: \_\_\_\_\_

Baby's ID #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Administering program/provider: \_\_\_\_\_ Was age adjusted for prematurity when selecting questionnaire?  Yes  No

**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	15.64		●	●	●	●	○	○	○	○	○	○	○	○	○
Gross Motor	21.49		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	34.50		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	27.32		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	21.73		●	●	●	●	●	○	○	○	○	○	○	○	○

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

- |  |            |           |  |            |    |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?<br>Comments:    | Yes        | <b>NO</b> | 6. Concerns about vision?<br>Comments:   | <b>YES</b> | No |
| 2. Plays with sounds or seems to make words?<br>Comments:      | Yes        | <b>NO</b> | 7. Any medical problems?<br>Comments:    | <b>YES</b> | No |
| 3. Feet are flat on the surface most of the time?<br>Comments: | Yes        | <b>NO</b> | 8. Concerns about behavior?<br>Comments: | <b>YES</b> | No |
| 4. Concerns about not making sounds?<br>Comments:              | <b>YES</b> | No        | 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 baby's total score is in the  area, it is above the cutoff, and the baby's development appears to be on schedule.
- If the baby's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.
- If the baby'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						

**Purpose:** To identify children who need to be tested for lead exposure.

## Instructions

- If **Yes** or **Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Administered by: \_\_\_\_\_ Date \_\_\_\_\_

## Questions

	Yes or Don't Know	No
1. Does your child live in or visit a home, day-care or other building built before 1978?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child eat or chew on non-food things like paint chips or dirt?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have a family member or friend who has or did have an elevated blood lead level?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your child a newly arrived refugee or foreign adoptee?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child come in contact with an adult whose job or hobby involves lead exposure?	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>Examples</i></p> <ul style="list-style-type: none"> <li>• House construction or repair</li> <li>• Battery manufacturing or repair</li> <li>• Burning lead-painted wood</li> <li>• Automotive repair shop or junk yard</li> <li>• Going to a firing range or reloading bullets</li> <li>• Chemical preparation</li> <li>• Valve and pipe fittings</li> <li>• Brass/copper foundry</li> <li>• Refinishing furniture</li> <li>• Making fishing weights</li> <li>• Radiator repair</li> <li>• Pottery making</li> <li>• Lead smelting</li> <li>• Welding</li> </ul>		
7. Does your family use products from other countries such as pottery, health remedies, spices, or food?	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>Examples</i></p> <ul style="list-style-type: none"> <li>• Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkoht, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda</li> <li>• Cosmetics such as kohl, surma, and sindor</li> <li>• Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.</li> <li>• Foods canned or packaged outside the U.S.</li> </ul>		

**Test Immediately**



# Questions About Your Child and Tuberculosis (TB)

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Your Name \_\_\_\_\_

Today's Date \_\_\_\_\_

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a tuberculin skin test (TST). The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

Check the box that matches your answer:	Yes	No	Do Not Know
1. Has your child been tested for TB? If yes, when? Please tell us the date ___/___/___			
2. Have you ever been told that your child had a positive tuberculin skin test (TST)? If yes, when? Please tell us the date ___/___/___			
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood.			
a. Has your child been around anyone with any of these problems?			
b. Has your child been around anyone sick with TB?			
c. Has your child ever had any of these problems or do they have them now?			
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? Which country or countries did your child visit? _____			
6. Do you know if your child has spent more than 3 weeks with anyone who:			
Uses needles for drug use?			
Has AIDS?			
Was or is in jail or prison?			
Has just come to the United States from another country?			

## FOR THE PROVIDER:

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.

If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.

If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

TST administered Yes \_\_\_ No \_\_\_

If yes, Date administered \_\_\_/\_\_\_/\_\_\_ Date read \_\_\_/\_\_\_/\_\_\_ TST reaction \_\_\_\_\_ mm

TST provider \_\_\_\_\_  
Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

If chest x-ray done, date \_\_\_\_\_ and results \_\_\_\_\_

Provider phone number \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

If positive, referral to local/regional health department/specialist? Yes \_\_\_ No \_\_\_

If yes, name of health dept./specialist \_\_\_\_\_

Contact your local or regional health department if assistance is needed.