





# 27 Month Questionnaire

25 months 16 days  
through 28 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:

### Notes:

- 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 \_\_\_\_\_.

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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." <input type="radio"/> b. "Close the door." <input type="radio"/> e. "Take my hand." <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? Please give an example:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<div style="border: 1px solid black; border-radius: 20px; 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"/>	_____

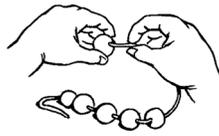
COMMUNICATION TOTAL \_\_\_\_\_

## 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. <i>(You can look for this at a store, on a playground, or at home.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
2. Does your child run fairly well, stopping herself without bumping into things or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
3. Does your child jump with both feet leaving the floor at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
4. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
5. Does your child jump forward at least 3 inches with both feet leaving the ground at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
6. Does your child walk up stairs, using only one foot on each stair? <i>(The left foot is on one step, and the right foot is on the next.)</i> She may hold onto the railing or wall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____ *
				
<b>GROSS MOTOR TOTAL</b>				_____

*\*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"/>	___
	Count as "yes"  Count as "not yet" 			
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"/>	___
	Count as "yes"  Count as "not yet" 			

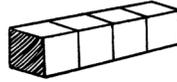
FINE MOTOR TOTAL \_\_\_

**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 he 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)

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.)



YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

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:



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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PROBLEM SOLVING TOTAL \_\_\_\_\_

**PERSONAL-SOCIAL**

1. If you do any of the following gestures, does your child copy at least one of them?

- |   |  |
|---|--|
| <input type="radio"/> a. Open and close your mouth. | <input type="radio"/> c. Pull on your earlobe. |
| <input type="radio"/> b. Blink your eyes.           | <input type="radio"/> d. Pat your cheek.       |

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

2. Does your child eat with a fork?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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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?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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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?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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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."

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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6. Does your child put on a coat, jacket, or shirt by himself?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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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



# 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						