



Ages & Stages Questionnaires®

18 Month Questionnaire

17 months 0 days through 18 months 30 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 date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's gender: ☐ Male ☐ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child: ☐ Parent ☐ Guardian ☐ Teacher ☐ Child care provider

Street address: _____ ☐ 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 #: _____ Age at administration in months and days: _____

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

Program name: _____



18 Month Questionnaire

17 months 0 days
through 18 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:

- ☒ 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:

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. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "yes" even if her words are difficult to understand.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?") Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION TOTAL _____

GROSS MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child move around by walking, rather than by crawling on her hands and knees? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child walk well and seldom fall? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child climb on an object such as a chair to reach something he wants (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"/> | — |
| 5. Does your child walk down stairs if you hold onto one of her hands? She may also 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"/> | — |
| 6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? <i>(If your child already kicks a ball, mark "yes" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



GROSS MOTOR TOTAL —

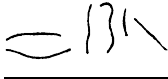

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child throw a small ball with a forward arm motion? <i>(If he simply drops the ball, mark "not yet" for this item.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child stack a small block or toy on top of another one? <i>(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. Does your child stack three small blocks or toys on top of each other by himself? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child turn the pages of a book by himself? <i>(He may turn more than one page at a time.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |



FINE MOTOR TOTAL —

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-------|
| 1. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in <i>any direction</i> ? (Mark "not yet" if your child scribbles back and forth.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <div style="display: flex; align-items: center;"> <div style="margin-right: 20px;"> <p>Count as "yes"</p>  <p>Count as "not yet"</p>  </div> </div> | | | | |
| 6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ * |

PROBLEM SOLVING TOTAL

*If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. While looking at herself in the mirror, does your child offer a toy to her own image? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child drink from a cup or glass, putting it down again with little spilling? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair? | <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. Do you think your child hears well? If no, explain:

☐ YES

☐ NO

2. Do you think your child talks like other toddlers his 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 her 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



18 Month ASQ-3 Information Summary

17 months 0 days through
18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child'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	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	●	○	○	○	○	○	○	○

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

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

STAGES OF HEARING, LANGUAGE, AND SPEECH DEVELOPMENT FROM BIRTH TO 5 YEARS CHECKLIST

Please use this checklist! Look at your checklist often. Find your child's age level. Check Yes or No for every item.
If your child does not pass any two items within an age level, call your doctor to make an appointment.

Age Level	Hearing and Understanding	Check One	Speech	Check One
Birth to 3 months	<ul style="list-style-type: none"> Gives a startle response to loud, sudden noises within 3 feet. Calms to a familiar, friendly voice. Wakes up when you speak or make noise nearby. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Coos and gurgles. Laughs and uses voice when playing. Watches your face when spoken to. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
3 to 6 months	<ul style="list-style-type: none"> Looks to see where sounds come from. Becomes frightened by an angry voice. Smiles when spoken to. Likes to play with toys or objects that make noise. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Babbles (uses a series of sounds). Makes at least 4 different sounds when using his or her voice. Babbles to people when they speak. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
6 to 9 months	<ul style="list-style-type: none"> Turns and looks to you when you are speaking in a quiet voice. Waves when you say "bye-bye." Stops for a moment when you say "no-no." Looks at objects or pictures when someone talks about them. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Babbles using "song-like tunes." Uses voice to get your attention instead of crying. Uses different sounds and appears to be naming things. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
9 to 12 months	<ul style="list-style-type: none"> Points to or looks at familiar objects or people when asked to. Looks sad when scolded. Follows directions ("Open your mouth," "Give me the ball"). "Dances" and makes sounds to music. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Uses jargon (appears to be talking). Uses consonant sounds like b, d, g, m, and n when talking. Jabbers in response to a human voice, changes loudness of voice, and uses rhythm and tone. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
NOTE: Be aware that babies between 12 to 15 months old say their first true words.				
12 to 18 months	<ul style="list-style-type: none"> Points to body parts (hair, eyes, nose, mouth) when asked to. Brings objects to you when asked. Hears and identifies sounds coming from another room or from outside. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Gives one-word answers to questions. Imitates many new words. Uses words of more than one syllable with meaning ("bottle"). Speaks 10 to 20 words. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
18 to 24 months	<ul style="list-style-type: none"> Understands simple "yes/no" questions. Understands simple phrases with prepositions ("in the cup"). Enjoys being read to and points to pictures when asked. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Uses his or her own first name. Uses "my" to get toys and other objects. Tells experiences using jargon and words. Uses 2-word sentences like "my shoes," "go bye-bye," "more juice." 	Yes <input type="checkbox"/> No <input type="checkbox"/>

Flip chart over to see the checklist for 24 months to 5 years of age. ►

HEARING CHECKLIST FOR PARENTS

(continued from the other side)

Age Level	Hearing and Understanding	Check One	Speech	Check One
24 to 30 months	<ul style="list-style-type: none"> Understands negative statements ("no more," "not now"). Selects objects according to size (big, little). Follows simple directions ("Get your shoes and socks"). 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Answers questions ("What do you do when you are sleepy?"). Uses plural words (2 books, dogs). Speaks 100 to 200 words. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
30 to 36 months	<ul style="list-style-type: none"> Understands uses of objects ("Show me what goes on your foot"). Understands the concept of one and can hand you one of something (1 ball, 1 cookie). Correctly identifies boys and girls. Understands many action words like "run" or "jump." 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Uses question forms correctly (who? what? where? when?). Uses negative forms ("It is not," "I can't"). Relates experiences using 4- to 5-word sentences. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
3 to 4 years	<ul style="list-style-type: none"> Understands "why" questions ("Why do you wash your hands?"). Understands opposites like "fast" or "slow." Correctly selects objects according to color. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Uses different forms of action words ("I play," "I want to play," "We played"). Counts to 10. Tells you about pictures in books or about a drawing ("I made a purple flower"). 	Yes <input type="checkbox"/> No <input type="checkbox"/>
4 to 5 years	<ul style="list-style-type: none"> Understands size comparisons (big, bigger, biggest). Understands many pronouns ("Give it to her," "Give it to him"). Follows a 2- to 3-step command ("Go to the kitchen, get a cup, put it on the table"). 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> Speaks at least 1,500 words. Says most sounds correctly except possibly "s" and "th." Talks freely to family and friends using full sentences that most people can understand. 	Yes <input type="checkbox"/> No <input type="checkbox"/>

Do you hear me?

This may be the most important question you ever answer for your baby.

- Babies learn to talk during their first years. Words help them share thoughts and feelings with the important people in their world.
- As your baby hears words, language and learning begin and speech develops.
- The checklist above and on the other side shows you how learning helps the speech development of your child.
- Watch your child grow through stages of normal hearing and speech development. Seek help immediately if your child is not developing according to the checklist.

What can you do?

- Some infants are born with normal hearing and later become deaf or hard of hearing. That is why you must continue to fill out the checklist.
- If you think your child has a hearing problem, **do not delay**. Seek help **immediately**.

NOW...

- You know your child best. If you suspect a possible hearing loss, talk to your doctor about getting a hearing test.
- For questions or more information, contact Texas Early Hearing Detection and Intervention (TEHDI).
Phone: **1-800-252-8023, ext. 7726** toll free
(Use relay option of your choice to call if needed.)
Email: tehdi@dshs.texas.gov
Website: www.dshs.texas.gov/tehdi

Lead Risk Questionnaire

Form Pb-110

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"/>
Examples <ul style="list-style-type: none"> • House construction or repair • Battery manufacturing or repair • Burning lead-painted wood • Automotive repair shop or junk yard • Going to a firing range or reloading bullets • Chemical preparation • Valve and pipe fittings • Brass/copper foundry • Refinishing furniture • Making fishing weights • Radiator repair • Pottery making • Lead smelting • Welding 		
7. Does your family use products from other countries such as pottery, health remedies, spices, or food?	<input type="checkbox"/>	<input type="checkbox"/>
Examples <ul style="list-style-type: none"> • Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda • Cosmetics such as kohl, surma, and sindor • Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins. • Foods canned or packaged outside the U.S. 		

Test Immediately

Texas Department of State Health Services
Tuberculosis (TB) Questionnaire for Children

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) or a TB blood test (called an IGRA) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box	Yes	No	Don't Know
TB can cause a fever of long duration, unexplained weight loss, a cough (lasting over two weeks), or coughing up blood. As far as you know has your child: <ul style="list-style-type: none">• been around anyone with any of these symptoms or problems? or• had any of these symptoms or problems? or• been around anyone sick with TB?			
Was your child born in: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries:			
To your knowledge, has your child spent time (longer than 3 weeks) with: anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? ☐ Yes (specify date ____/____/____) ☐ No
Has your child ever had a positive TB skin test? ☐ Yes (specify date ____/____/____) ☐ No
Has your child ever had a positive TB blood test? ☐ Yes (specify date ____/____/____) ☐ No

For school/healthcare provider use only

PPD / IGRA administered (circle one)

Date Administered: ____/____/____ Date Read (if PPD): ____/____/____

Result of PPD: _____ mm Result of IGRA test: ☐ Positive ☐ Negative ☐ Indeterminate/Invalid

Type of service provider (i.e. school, Health Steps, other clinics): _____

PPD/IGRA provider: _____
signature printed name

Provider phone number: _____

City _____ County _____

If positive, referral to healthcare provider: ☐ Yes ☐ No

If yes, name/contact of provider: _____



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.

- | | Yes | No |
|--|-----|----|
| 1. 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?) | | |
| 2. Have you ever wondered if your child might be deaf? | | |
| 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?) | | |
| 4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs) | | |
| 5. Does your child make <u>unusual</u> finger movements near his or her eyes?
(FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?) | | |
| 6. 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. 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) | | |
| 8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?) | | |
| 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) | | |
| 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?) | | |
| 11. When you smile at your child, does he or she smile back at you? | | |
| 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?) | | |
| 13. Does your child walk? | | |
| 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? | | |
| 15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do) | | |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at? | | |
| 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”?) | | |
| 18. 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 on the chair” or “bring me the blanket”?) | | |
| 19. 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 sees a new toy, will he or she look at your face?) | | |
| 20. Does your child like movement activities?
(FOR EXAMPLE , being swung or bounced on your knee) | | |