22 months

Please complete these forms before your visit today.

Thank you!

ASQ-3 Ages & Stages Questionnaires®

22 Month Questionnaire

21 months 0 days through 22 months 30 days

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

Date ASQ completed: _____

For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

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 say 15 or more words in addition to "Mama" and "Dada"?	◯	◯	◯	____
5. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	◯	◯	◯	____
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:	◯	◯	◯	____

COMMUNICATION TOTAL ____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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? *(If your child already kicks a ball, mark "yes" for this item.)* 	○	○	○	____
2. Does your child run fairly well, stopping herself without bumping into things or falling? 	○	○	○	____
3. Does your child walk down stairs if you hold onto one of his hands? He may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	○	○	○	____
4. Does your child walk either up or down at least two steps by herself? He may hold onto the railing or wall. 	○	○	○	____
5. Does your child jump with both feet leaving the floor at the same time? 	○	○	○	____
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	○	○	○	____*
			GROSS MOTOR TOTAL	____

**If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."*

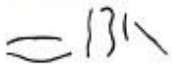
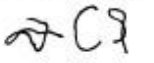
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	○	○	○	____
2. Does your child stack six small blocks or toys on top of each other by himself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	____

FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
3. 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?	○	○	○	____
4. Does your child turn the pages of a book by himself? *(He may turn more than one page at a time.)*	○	○	○	____
5. Does your child flip switches off and on?	○	○	○	____
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	____
			FINE MOTOR TOTAL	____

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	○	○	○	____
2. 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 at least two blocks side by side? *(You can also use spools of thread, small boxes, or other toys.)* 	○	○	○	____
3. 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 his head, pretending it is a hat? Does he use a block or small toy to stir food?	○	○	○	____
4. 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 *any direction*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	○	○	○	____
5. 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 her how.) (You can use a soda-pop bottle or a baby bottle.)*	○	○	○	____
6. If you give your child a bottle, spoon, or pencil upside down, does he turn it right side up so that he can use it properly?	○	○	○	____
			PROBLEM SOLVING TOTAL	____

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	◯	◯	◯	____
2. If you do any of the following gestures, does your child copy at least one of them?	◯	◯	◯	____
◯ a. Open and close your mouth. ◯ b. Blink your eyes.				
◯ c. Pull on your earlobe. ◯ d. Pat your cheek.				
3. Does your child eat with a fork?	◯	◯	◯	____
4. Does your child drink from a cup or glass, putting it down again with little spilling?	◯	◯	◯	____
5. 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?	◯	◯	◯	____
6. 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?	◯	◯	◯	____
			PERSONAL-SOCIAL TOTAL	____

M-CHAT-R™

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? (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 unusual finger movements near his or her eyes? (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? (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? (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? (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? (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? (FOR EXAMPLE, being swung or bounced on your knee)	Yes	No

Staying Healthy Assessment

1-2 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐Guardian ☐ Other (specify)			Need Help with Form ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you breastfeed your child?	Yes	No	Skip	*Nutrition*
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Does your child eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
4	Does your child eat high-fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
5	Does your child drink more than one small cup (4 – 6 oz.) of juice per day?	No	Yes	Skip	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
7	Does your child play actively most days of the week?	Yes	No	Skip	*Physical Activity*
8	Are you concerned about your child's weight?	No	Yes	Skip	
9	Does your child watch TV or play video games?	No	Yes	Skip	
10	Does your home have a working smoke detector?	Yes	No	Skip	*Safety*
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
13	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear-facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the correct one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	

21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	*Dental Health*
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	*Drug, Alcohol & Tobacco Exposure*
24	Does your child have any family members who have or have had a problem with alcohol or other drugs?	No	Yes	Skip	
25	Does your child have any family members who suffer from depression, anxiety, PTSD or other mental health conditions?	No	Yes	Skip	*Home Environment*
26	(For parents) Does a partner, or anyone at home, hurt, hit or threaten you?	No	Yes	Skip	
27	Has your child ever been away from either parent due to parental illness, separation, foster care, parental incarceration or other reasons?	No	Yes	Skip	
28	Has anything really scary or upsetting happened to your child or anyone in your family?	No	Yes	Skip	
29	In the last year, have you been worried that your food would run out before you were able to get more?	No	Yes	Skip	*Other Questions*
30	In the last year, have you been worried that you would need to move out of a place you were staying due to inability to afford the rent, or for other reasons?	No	Yes	Skip	
31	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Drug, Alcohol & Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**
☐ Home Environment	☐	☐	☐	☐	
PCP's Signature:	Print Name:				Date:
SHA ANNUAL REVIEW					
PCP's Signature:	Print Name:				Date:

GARDNER
Packard Children's Health Center

Family Needs Screening[1,2]

Our goal at Gardner Packard Children's Health Center is to provide the best possible care for your child and family. We would like to make sure you know resources available to you for your family's needs. Please answer both questions and give to your child's doctor at the beginning of the visit. Thank You!

1. Which of these would you like help with today? (Check all that apply)

   - ❑ Food
   - ❑ Housing
   - ❑ Living conditions (like mold in your home)
   - ❑ Utilities
   - ❑ Transportation
   - ❑ Tutoring or Homework Help
   - ❑ Childcare or preschool

   - ❑ None of these

2. Which of the concerns above is most important to talk about today?

Adapted from: [1] Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health Related Social Needs Screening Tool and [2] WE-CARE: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education. Modified on 6/12/2018.