



26 months

Please complete these forms before your visit today.

Thank you!



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







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. 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: 15px; height: 40px; 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.)		<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? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or wall.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____*

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"/>	___
	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 ___

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 <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?) | 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	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	In Child/Day Care <input type="checkbox"/> Yes <input type="checkbox"/> No
Person Completing Form	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (specify)			Need Help with Form <input type="checkbox"/> Yes <input type="checkbox"/> 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:

					Nutrition
1	Do you breastfeed your child?	Yes	No	Skip	
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	
					Physical Activity
7	Does your child play actively most days of the week?	Yes	No	Skip	
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	
					Safety
10	Does your home have a working smoke detector?	Yes	No	Skip	
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	<i>Dental Health</i>
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	<i>Drug, Alcohol & Tobacco Exposure</i>
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	<i>Home Environment</i>
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	<i>Other Questions</i>
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:	
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Drug, Alcohol & Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Home Environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PCP's Signature:					Print Name:	Date:
SHA ANNUAL						
PCP's Signature:					Print Name:	Date:



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?