32 months

Please complete these forms before your visit today.

Thank you!

ASQ-3 Ages & Stages Questionnaires®

33 Month Questionnaire

31 months 16 days through 34 months 15 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 child is doing the activity regularly, sometimes, or not yet.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When you ask your child to point to his nose, eyes, hair, feet, ears, and so forth, does he correctly point to at least ***seven*** body parts? *(He can point to parts of himself, you, or a doll. Mark "sometimes" if he correctly points to at least three different body parts.)*	○	○	○	___
2. Does your child make sentences that are three or four words long? Please give an example:	○	○	○	___
3. Without giving your child help by pointing or using gestures, ask her to "put the book ***on*** the table" and "put the shoe ***under*** the chair." Does your child carry out both of these directions correctly?	○	○	○	___
4. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying"). You may ask, "What is the dog (or boy) doing?"	○	○	○	___
5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle, and ask your child to move the zipper ***down***. Return the zipper to the middle, and ask your child to move the zipper ***up***. Do this several times, placing the zipper in the middle before asking your child to move it up or down. Does your child consistently move the zipper up when you say "up" and down when you say "down"?	○	○	○	___
6. When you ask, "What is your name?" does your child say his first name or nickname?	○	○	○	___
			COMMUNICATION TOTAL	___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling? 	○	○	○	___
2. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	○	○	○	___
3. Does your child jump with both feet leaving the floor at the same time? 	○	○	○	___
4. 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. *(You can look for this at a store, on a playground, or at home.)* 	○	○	○	___
5. Does your child stand on one foot for about 1 second without holding onto anything? 	○	○	○	___
6. While standing, does your child throw a ball *overhand* by raising his arm to shoulder height and throwing the ball forward? *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")* 	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, 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 vertical direction?	○	○	○	___

Count as "yes"

1 7 1

Count as "not yet"

-C 3

FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	

2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

○ ○ ○ ___

3. After your child watches you draw a line from one side of the paper to the other side, 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 horizontal direction?

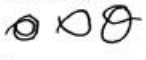
Count as "yes"

Count as "not yet"

○ ○ ○ ___

4. After your child watches you draw a single circle, ask her to make a circle like yours. Do not let her trace your circle. Does your child copy you by drawing a circle?

Count as "yes"



Count as "not yet"

○ ○ ○ ___

5. Does your child turn pages in a book, one page at a time?

○ ○ ○ ___

6. Does your child try to cut paper with child-safe scissors? He does not need to cut the paper but must get the blades to open and close while holding the paper with the other hand. *(You may show your child how to use scissors. Carefully watch your child's use of scissors for safety reasons.)*

○ ○ ○ ___

FINE MOTOR TOTAL ___

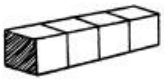
PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	

1. When looking in the mirror, ask, "Where is _____?" (Use your child's name.) Does your child point to her image in the mirror?

○ ○ ○ ___

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 *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)*



○ ○ ○ ___

3. If your child wants something he cannot reach, does he 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)?

○ ○ ○ ___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
4. 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: 	○	○	○	___
5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same order? ***Do not repeat the numbers.*** If necessary, try another pair of numbers and say, "Say 'eight two.'" *(Your child must repeat just one series of two numbers for you to answer "yes" to this question.)*	○	○	○	___
6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? *(You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child use a spoon to feed herself with little spilling?	○	○	○	___
2. 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?	○	○	○	___
3. Does your child put on a coat, jacket, or shirt by herself?	○	○	○	___
4. After you put on loose-fitting pants around his feet, does your child pull them completely up to his waist?	○	○	○	___
5. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?	○	○	○	___
6. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

Staying Healthy Assessment

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

21	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	*Dental Health*
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	*Drug, Alcohol & Tobacco Exposure*
23	Does your child have any family members who have or have had a problem with alcohol or other drugs?	No	Yes	Skip	
24	Does your child have any family members who suffer from depression, anxiety, PTSD or other mental health conditions?	No	Yes	Skip	*Home Environment*
25	(For parents) Does a partner, or anyone at home, hurt, hit or threaten you?	No	Yes	Skip	
26	Has your child ever witnessed or been a victim of abuse or violence?	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:
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.