



35 months

Please complete these forms before your visit today.

Thank you!



Ages & Stages Questionnaires®

36 Month Questionnaire

34 months 16 days through 38 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 child is doing the activity regularly, sometimes, or not yet.



COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. 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? (<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"/>	—
2. 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: 50px; width: 100%;"></div>				
3. Without giving your child help by pointing or using gestures, ask him to "put the book on the table" and "put the shoe under the chair." Does your child carry out both of these directions correctly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you ask, "What is your name?" does your child say both her first and last names?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
COMMUNICATION TOTAL				—


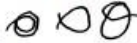




GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. 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"/>	—
2. Does your child jump with both feet leaving the floor at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. 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.) She may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)</i>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child stand on one foot for about 1 second without holding onto anything?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. While standing, does your child throw a ball <i>overhand</i> by raising his arm to shoulder height and throwing the ball forward? <i>(Dropping the ball or throwing the ball underhand should be scored as "not yet.")</i>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				GROSS MOTOR TOTAL	—

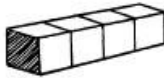
FINE MOTOR

		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"  <hr/> Count as "not yet" 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<p>Count as "yes" </p> <p>Count as "not yet" </p>			
4. 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"/>	—
	<p>Count as "yes" </p> <p>Count as "not yet" </p>			
5. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	FINE MOTOR TOTAL			—

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. 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 <i>four</i> objects in a row? (You can also use spools of thread, small boxes, or other toys.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. 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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING (continued)

3. 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:



4. 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.)

5. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it?



6. When you say, "Say 'five eight three,'" does your child repeat *just* the three numbers in the same order? *Do not repeat the numbers.* If necessary, try another series of numbers and say, "Say 'six nine two.'" (Your child must repeat just one series of three numbers for you to answer "yes" to this question.)

	YES	SOMETIMES	NOT YET	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PROBLEM SOLVING TOTAL				—

PERSONAL-SOCIAL

1. Does your child use a spoon to feed herself with little spilling?
2. Does your child push a little wagon, stroller, or toy on wheels, steering it around objects and backing out of corners if he cannot turn?
3. 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?
4. Does your child put on a coat, jacket, or shirt by himself?
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?
6. Does your child take turns by waiting while another child or adult takes a turn?

	YES	SOMETIMES	NOT YET	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PERSONAL-SOCIAL TOTAL				—

Staying Healthy Assessment

3-4 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:

							<i>Nutrition</i>		
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					
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					
							<i>Physical Activity</i>		
6	Does your child play actively most days of the week?	Yes	No	Skip					
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					
							<i>Safety</i>		
9	Does your home have a working smoke detector?	Yes	No	Skip					
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	Other Questions
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	
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"/> Patient Declined the SHA
<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 REVIEW					
PCP's Signature:		Print Name:		Date:	
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?