

# **Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System Second Edition**

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

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## ◆ **18 Month** ◆ **Questionnaire**



On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

### ***Important Points to Remember:***

- Be sure to try each activity with your child before checking a box.
- Try to make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested, fed, and ready to play.
- Please return this questionnaire by \_\_\_\_\_.
- If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_.
- Look forward to filling out another questionnaire in \_\_\_\_\_ months.

**\*\*\*PLEASE NOTE\*\*\***

WE WILL BILL THIS SCREENING TO YOUR INSURANCE CARRIER IN THE EVENT IT IS NOT COVERED, YOU MAY BE FINANCIALLY RESPONSIBLE.



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◆ **18 Month** ◆  
**Questionnaire**

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

\_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

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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, score "yes" for the item.

YES      SOMETIMES      NOT YET

**COMMUNICATION**      *Be sure to try each activity with your child.*

- |  |                          |                          |                          |     |
|--|--------------------------|--------------------------|--------------------------|-----|
| 1. When your child wants something, does she tell you by <i>pointing</i> to it?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When you ask him to, does your child 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your child say eight or more words in addition to "Mama" and "Dada"?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 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? (Check "yes" even if her words are difficult to understand.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Without showing him first, 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 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?")      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

Please give an example of your child's word combinations:

\_\_\_\_\_

COMMUNICATION TOTAL      \_\_\_

**GROSS MOTOR**      *Be sure to try each activity with your child.*

- |   |                          |                          |                          |     |
|---|--------------------------|--------------------------|--------------------------|-----|
| 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. Does your child move around by walking, rather than by crawling on her hands and knees?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your child walk well and seldom fall?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child climb on an object such as a chair to reach something he wants?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your child walk down stairs if you hold onto one of her hands? (You can look for this at a store, on a playground, or at home.)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. When you show him how to kick a large ball, does your child try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, check "yes" for this item.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |



GROSS MOTOR TOTAL      \_\_\_

YES      SOMETIMES      NOT YET

**FINE MOTOR**      *Be sure to try each activity with your child.*

1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, check "not yet" for this item.)



                 \_\_\_\_\_

2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

                 \_\_\_\_\_

3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw?



                 \_\_\_\_\_

4. Does your child stack three small blocks or toys on top of each other by herself? (You can also use spools of thread, small boxes, or toys that are about 1 inch in size.)

                 \_\_\_\_\_

5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)

                 \_\_\_\_\_

6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?

                 \_\_\_\_\_

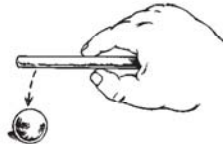
FINE MOTOR TOTAL \_\_\_\_\_

**PROBLEM SOLVING**      *Be sure to try each activity with your child.*

1. Does your child drop several (six or more) small toys into a container, such as a bowl or box? (You may show him how to do it.)

                 \_\_\_\_\_

2. After you have shown her how, does your child try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?



                 \_\_\_\_\_

3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child purposely turn the bottle over to dump it out? You may show him how to do this. You can use a plastic soda-pop bottle or baby bottle.

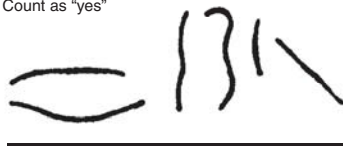
                 \_\_\_\_\_

4. Without first showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?

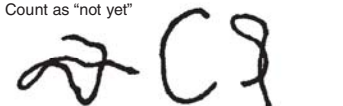
                 \_\_\_\_\_

5. After he watches 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*? (Scribbling back and forth does not count as "yes.")

Count as "yes"



Count as "not yet"



                 \_\_\_\_\_

YES    SOMETIMES    NOT YET

**PROBLEM SOLVING**    *(continued)*

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 her how.) (Please allow a few minutes between trying problem solving items 3 and 6.)

                                                                 \_\_\_\_\_ \*

PROBLEM SOLVING TOTAL \_\_\_\_\_

*\*If problem solving item 6 is marked "yes" or "sometimes," mark problem solving item 3 as "yes."*

**PERSONAL-SOCIAL**    *Be sure to try each activity with your child.*

1. While looking at himself in the mirror, does your child offer a toy to his own image?

                                                                 \_\_\_\_\_

2. Does your child play with a doll or stuffed animal by hugging it?

                                                                 \_\_\_\_\_

3. Does your child get your attention or try to show you something by pulling on your hand or clothes?

                                                                 \_\_\_\_\_

4. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?

                                                                 \_\_\_\_\_

5. Does your child drink from a cup or glass, putting it down again with little spilling?

                                                                 \_\_\_\_\_

6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

                                                                 \_\_\_\_\_

PERSONAL-SOCIAL TOTAL \_\_\_\_\_

**OVERALL**    *Parents and providers may use the space at the bottom of the next sheet for additional comments.*

1. Do you think your child hears well?

YES     NO

If no, explain: \_\_\_\_\_

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

YES     NO

If no, explain: \_\_\_\_\_

3. Can you understand most of what your child says?

YES     NO

If no, explain: \_\_\_\_\_

4. Do you think your child walks, runs, and climbs like other toddlers her age?

YES     NO

If no, explain: \_\_\_\_\_

5. Does either parent have a family history of childhood deafness or hearing impairment?

YES     NO

If yes, explain: \_\_\_\_\_

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**OVERALL** (continued)

6. Do you have concerns about your child's vision? YES  NO   
If yes, explain: \_\_\_\_\_
7. Has your child had any medical problems in the last several months? YES  NO   
If yes, explain: \_\_\_\_\_
8. Does anything about your child worry you? YES  NO   
If yes, explain: \_\_\_\_\_

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