

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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◆ **20 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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◆ **20 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. 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"/> | _____ |
| 2. Does your child say eight words or more in addition to "Mama" and "Dada"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. 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 ball?" (He needs to identify only one picture correctly.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. 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:
_____ | | | | |
| 5. 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Without giving him clues by pointing or using gestures, can your child carry out at least <i>three</i> 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." | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

COMMUNICATION TOTAL _____

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

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-------|
| 1. 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"/> | _____ |
| 2. Does your child walk well and seldom fall? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. 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"/> | _____ |
| 4. 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"/> | _____ |
| 5. Does your child run fairly well, stopping herself without bumping into things or falling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |



YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

6. Does your child walk either up or down at least two steps by himself? You can look for this at a store, on a playground, or at home. (Check "yes" even if he holds onto the wall or railing.)



GROSS MOTOR TOTAL _____

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

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



2. 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.)

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

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

5. Does your child stack six small blocks or toys on top of each other by himself?

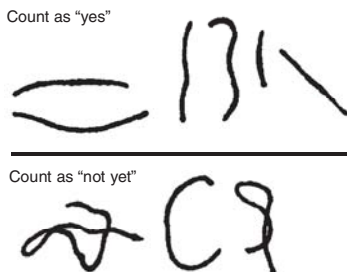
6. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

FINE MOTOR TOTAL _____

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

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

2. After she 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.")



3. 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.

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YES SOMETIMES NOT YET

PROBLEM SOLVING *(continued)*

- | | | | | | |
|----|--|---|--------------------------|--------------------------|------------------------------|
| 4. | 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 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 at least <i>two</i> blocks side by side? (You can also use spools of thread, small boxes, or other toys.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| | |  | | | |
| 6. | If your child wants something she cannot reach, does she find a chair or box to stand on to reach it? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| | | | | | PROBLEM SOLVING TOTAL ___ |

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

- | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|------------------------------|
| 1. | Does your child feed himself with a spoon, even though he may spill some food? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. | Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. | Does your child drink from a cup or glass, putting it down again with little spilling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. | Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. | When playing with either a stuffed animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. | Does your child eat with a fork? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| | | | | | 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 <input type="checkbox"/> | NO <input type="checkbox"/> |
| | | If no, explain: _____ | |
| 2. | Do you think your child talks like other toddlers her age? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| | | If no, explain: _____ | |
| 3. | Can you understand most of what your child says? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| | | If no, explain: _____ | |
| 4. | Do you think your child walks, runs, and climbs like other toddlers his age? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| | | If no, explain: _____ | |

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OVERALL (continued)

5. Does either parent have a family history of childhood deafness or hearing impairment? YES NO
If yes, explain: _____
6. Do you have any 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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