



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 4 YEAR VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

### WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today?  No  Yes, describe:

Blank space for describing concerns or questions.

### TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Blank space for describing what excites or delights the child.

Does your child have special health care needs?  No  Yes, describe:

Blank space for describing special health care needs.

Have there been major changes lately in your child's or family's life?  No  Yes, describe:

Blank space for describing major changes in life.

Have any of your child's relatives developed new medical problems since your last visit?  No  Yes  Unsure If yes or unsure, please describe:

Blank space for describing medical problems in relatives.

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes?  No  Yes  Unsure

### YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior?  No  Yes, describe:

Blank space for describing concerns about development, learning, or behavior.

#### Check off each of the tasks that your child is able to do.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Go to the bathroom and have a bowel movement by himself.                                | <input type="checkbox"/> Speak so strangers can understand 100% of what she says. | <input type="checkbox"/> Climb stairs, using one foot, then the other, without support. |
| <input type="checkbox"/> Dress and undress without much help.  | <input type="checkbox"/> Draw pictures you recognize.                             | <input type="checkbox"/> Draw a person with at least 3 body parts.                      |
| <input type="checkbox"/> Play make-believe.  | <input type="checkbox"/> Follow simple rules when playing board or card games.    | <input type="checkbox"/> Draw a simple cross.   |
| <input type="checkbox"/> Answer questions such as "What do you do when you are cold?" and "When you are sleepy?" | <input type="checkbox"/> Tell you a story from a book.                            | <input type="checkbox"/> Unbutton and button medium-sized buttons.                      |
| <input type="checkbox"/> Use 4-word sentences.   | <input type="checkbox"/> Skip on one foot.  | <input type="checkbox"/> Grasp a pencil with a thumb and fingers instead of her fist.   |

Please print.

## 4 YEAR VISIT

### RISK ASSESSMENT

<b>Anemia</b>	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Dyslipidemia</b>	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Lead</b>	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Oral health</b>	Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
<b>Tuberculosis</b>	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

### ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

#### YOUR FAMILY'S HEALTH AND WELL-BEING

<b>Living Situation and Food Security</b>		
Is permanent housing a worry for you?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have enough heat, hot water, electricity, and working appliances?	<input type="radio"/> Yes	<input type="radio"/> No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Alcohol and Drugs</b>		
Does anyone in your household drink beer, wine, or liquor?	<input type="radio"/> No	<input type="radio"/> Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Intimate Partner Violence</b>		
Do you always feel safe in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Safety in the Community</b>		
Do you feel safe in your community?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have someone you can turn to if you are concerned about your child's safety?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have connections to your community through faith groups, volunteer organizations, or recreational programs?	<input type="radio"/> Yes	<input type="radio"/> No
Do you spend time with parents of other children in your community?	<input type="radio"/> Yes	<input type="radio"/> No

#### GETTING READY FOR SCHOOL

<b>Language Understanding and Fluency</b>		
Does your child clearly communicate his wants and needs to you and others?	<input type="radio"/> Yes	<input type="radio"/> No
Do you respond to your child's questions with short and simple answers?	<input type="radio"/> Yes	<input type="radio"/> No
Do you give your child plenty of time to tell a story or answer a question?	<input type="radio"/> Yes	<input type="radio"/> No
Do you talk, sing, and read together every day?	<input type="radio"/> Yes	<input type="radio"/> No

## 4 YEAR VISIT

### GETTING READY FOR SCHOOL (CONTINUED)

Feelings		
Is your child generally happy and active?	<input type="radio"/> Yes	<input type="radio"/> No
Do you help your child say, "I'm sorry," for hurting others' feelings?	<input type="radio"/> Yes	<input type="radio"/> No
Opportunities to Socialize With Other Children		
Is your child interested in other children?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a chance to play with other children in playgroups or at preschool?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a best friend?	<input type="radio"/> Yes	<input type="radio"/> No
Do you praise your child when she is good or has finished a task?	<input type="radio"/> Yes	<input type="radio"/> No
Early Childhood Programs and Preschool		
Does your child attend preschool?	<input type="radio"/> Yes	<input type="radio"/> No
Are you happy with your child care or preschool arrangement?	<input type="radio"/> Yes	<input type="radio"/> No
Do you visit your child's preschool and participate in activities there?	<input type="radio"/> Yes	<input type="radio"/> No
Readiness for School		
Do you have any concerns about your child starting school in the coming year?	<input type="radio"/> No	<input type="radio"/> Yes
Are you doing things to get your child ready for preschool? This could include reading together and going to the library, the park, the zoo, and other places.	<input type="radio"/> Yes	<input type="radio"/> No

### HEALTHY HABITS

Nutrition		
Does your child drink water every day?	<input type="radio"/> Yes	<input type="radio"/> No
How many ounces of milk does your child drink on most days?	_____ oz	
Do you offer your child a variety of foods, including vegetables, fruits, and foods rich in protein, such as meat, eggs, chicken, or fish?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child willing to try new flavors and food textures?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your child decide how much to eat and when to stop?	<input type="radio"/> Yes	<input type="radio"/> No
Daily Routines That Promote Health		
Does your child sleep well?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a regular bedtime and mealtime routines?	<input type="radio"/> Yes	<input type="radio"/> No
Do you brush your child's teeth twice a day with a pea-sized amount of fluoridated toothpaste?	<input type="radio"/> Yes	<input type="radio"/> No

### LIMITING TV AND PROMOTING PHYSICAL ACTIVITY

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	<input type="radio"/> No	<input type="radio"/> Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play actively for at least 1 hour a day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play with other children?	<input type="radio"/> Yes	<input type="radio"/> No
Are you physically active together as a family, such as going for walks or playing in the park?	<input type="radio"/> Yes	<input type="radio"/> No

### SAFETY

Car Safety		
Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 4 YEAR VISIT

### SAFETY (CONTINUED)

Outdoor Safety		
Do you watch your child closely when she plays outside, especially near streets and driveways?	<input type="radio"/> Yes	<input type="radio"/> No
Are there swimming pools in your neighborhood?	<input type="radio"/> No	<input type="radio"/> Yes
Are you planning to have your child learn to swim?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always use sunscreen when he plays outside?	<input type="radio"/> Yes	<input type="radio"/> No
Pets		
Do you own a pet?	<input type="radio"/> No	<input type="radio"/> Yes
Have you taught your child how to behave around animals so she does not get bitten or scratched?	<input type="radio"/> Yes	<input type="radio"/> No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*

For more information, go to <https://brightfutures.aap.org>.





# Ages & Stages Questionnaires®

## 48 Month Questionnaire

45 months 0 days through 50 months 30 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

Child's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Child's last name: \_\_\_\_\_

Child's gender:  
 Male  Female

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

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Relationship to child:

- Parent
- Guardian
- Teacher
- Child care provider
- Grandparent or other relative
- Foster parent
- Other: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP/Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Names of people assisting in questionnaire completion: \_\_\_\_\_

### Program Information

Child ID #: \_\_\_\_\_

Program ID #: \_\_\_\_\_

Program name: \_\_\_\_\_



# 48 Month Questionnaire

45 months 0 days  
through 50 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

### Important Points to Remember:

### Notes:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.
- Please return this questionnaire by \_\_\_\_\_.

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## COMMUNICATION

YES                      SOMETIMES                      NOT YET

1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?

                                                                 \_\_\_\_\_

2. Does your child answer the following questions? (Mark "sometimes" if your child answers only one question.)

                                                                 \_\_\_\_\_

"What do you do when you are hungry?" (Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.") Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.") Please write your child's response:

3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?

                                                                 \_\_\_\_\_




4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?

                                                                 \_\_\_\_\_

**COMMUNICATION** (continued)

	YES	SOMETIMES	NOT YET	
5. Without your giving help by pointing or repeating, does your child follow three directions that are <i>unrelated</i> to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I am going to the park," or "Is there a toy to play with?" or "Are you coming, too?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
COMMUNICATION TOTAL				___

**GROSS MOTOR**

	YES	SOMETIMES	NOT YET	
1. Does your child catch a large ball with both hands? (You should stand about 5 feet away and give your child two or three tries before you mark the answer.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. While standing, does your child throw a ball <i>overhand</i> in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. (Dropping the ball or throwing the ball underhand should be scored as "not yet.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? (You may give your child two or three tries before you mark the answer.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
GROSS MOTOR TOTAL				___

**FINE MOTOR**

	YES	SOMETIMES	NOT YET	
1. Does your child put together a five- to seven-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

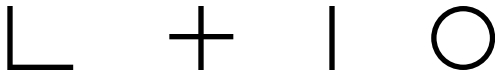
**FINE MOTOR** (continued)

2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.)



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

3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? (Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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4. Does your child unbutton one or more buttons? (Your child may use his own clothing or a doll's clothing.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? (Your child should not go more than 1/4 inch outside the lines on most of the picture.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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FINE MOTOR TOTAL —

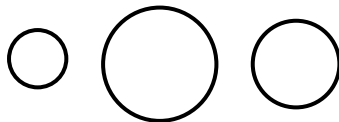
**PROBLEM SOLVING**

1. 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 to answer "yes" to this question.)

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

2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? (Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "under the couch." Then ask her to put the ball "between the chairs" and the book "in the middle of the table."

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? (Mark "yes" only if your child answers the question correctly using five colors.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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## PROBLEM SOLVING (continued)

- |   | YES                   | SOMETIMES             | NOT YET               |     |
|---|-----------------------|-----------------------|-----------------------|-----|
| 5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? <i>(Ask this question without providing help by pointing, gesturing, or naming.)</i>                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| PROBLEM SOLVING TOTAL   |                       |                       |                       | ___ |

## PERSONAL-SOCIAL

- |   | YES                   | SOMETIMES             | NOT YET               |     |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child tell you at least four of the following? Please mark the items your child knows.   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <input type="radio"/> a. First name <input type="radio"/> d. Last name<br><input type="radio"/> b. Age <input type="radio"/> e. Boy or girl<br><input type="radio"/> c. City she lives in <input type="radio"/> f. Telephone number |                       |                       |                       |     |
| 3. Does your child wash his hands using soap and water and dry off with a towel without help?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child tell you the names of two or more playmates, not including brothers and sisters? <i>(Ask this question without providing help by suggesting names of playmates or friends.)</i>                                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? <i>(You may still need to check and rebrush your child's teeth.)</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| PERSONAL-SOCIAL TOTAL   |                       |                       |                       | ___ |

## OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:  YES                       NO

**OVERALL** (continued)

2. Do you think your child talks like other children her age? If no, explain:

 YES NO

3. Can you understand most of what your child says? If no, explain:

 YES NO

4. Can other people understand most of what your child says? If no, explain:

 YES NO

5. Do you think your child walks, runs, and climbs like other children his age?  
If no, explain:

 YES NO

6. Does either parent have a family history of childhood deafness or hearing  
impairment? If yes, explain:

 YES NO

7. Do you have any concerns about your child's vision? If yes, explain:

 YES NO

**OVERALL** (continued)

8. Has your child had any medical problems in the last several months? If yes, explain:

 YES NO

9. Do you have any concerns about your child's behavior? If yes, explain:

 YES NO

10. Does anything about your child worry you? If yes, explain:

 YES NO





# 48 Month ASQ-3 Information Summary

45 months 0 days through  
50 months 30 days

Child's name: \_\_\_\_\_ Date ASQ completed: \_\_\_\_\_  
 Child's ID #: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Administering program/provider: \_\_\_\_\_

**1. SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	30.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	○	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○

**2. TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |   |     |           |   |            |    |
|---|-----|-----------|---|------------|----|
| 1. Hears well?<br>Comments:                                     | Yes | <b>NO</b> | 6. Family history of hearing impairment?<br>Comments: | <b>YES</b> | No |
| 2. Talks like other children his age?<br>Comments:              | Yes | <b>NO</b> | 7. Concerns about vision?<br>Comments:                | <b>YES</b> | No |
| 3. Understand most of what your child says?<br>Comments:        | Yes | <b>NO</b> | 8. Any medical problems?<br>Comments:                 | <b>YES</b> | No |
| 4. Others understand most of what your child says?<br>Comments: | Yes | <b>NO</b> | 9. Concerns about behavior?<br>Comments:              | <b>YES</b> | No |
| 5. Walks, runs, and climbs like other children?<br>Comments:    | Yes | <b>NO</b> | 10. Other concerns?<br>Comments:                      | <b>YES</b> | No |

**3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the  area, it is above the cutoff, and the child's development appears to be on schedule.  
 If the child's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.  
 If the child's total score is in the  area, it is below the cutoff. Further assessment with a professional may be needed.

**4. FOLLOW-UP ACTION TAKEN:** Check all that apply.

- Provide activities and rescreen in \_\_\_\_\_ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_.
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): \_\_\_\_\_

**5. OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						