

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

18 MONTH 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. **Child Development and Autism Spectrum Disorder screenings are also part of this visit.** 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:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

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

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

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

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:

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

- Engage with others for play.
- Turn and look at an adult if something new happens.
- Walk up with 2 feet per step with his hand held.
- Help dress and undress himself.
- Begin to scoop with a spoon.
- Sit in a small chair.
- Point to pictures in a book.
- Use words to ask for help.
- Carry a toy while walking.
- Point to an interesting object to draw your attention to it.
- Identify at least 2 body parts.
- Scribble spontaneously.
- Name at least 5 familiar objects, such as ball or milk.
- Throw a small ball a few feet while standing.

Please print.

18 MONTH VISIT

RISK ASSESSMENT

Anemia	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
Hearing	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Lead	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
Oral health	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
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your child's eyes ever been injured?	<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 CHILD'S BEHAVIOR

Do you praise your child for good behavior?	<input type="radio"/> Yes	<input type="radio"/> No
If your child is upset, do you help distract him with another activity, book, or toy?	<input type="radio"/> Yes	<input type="radio"/> No
Do other caregivers set the same limits for your child as you do?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use time-outs as a way to manage your child's behavior?	<input type="radio"/> Yes	<input type="radio"/> No
Have you thought about toilet training?	<input type="radio"/> Yes	<input type="radio"/> No
If you are planning to have another baby, have you thought about how you will prepare your child?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No

TALKING AND COMMUNICATING

Do you read, sing, and talk with your child about what you are seeing and doing?	<input type="radio"/> Yes	<input type="radio"/> No
Does he wave "bye-bye"?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use simple words to tell your child what to do?	<input type="radio"/> Yes	<input type="radio"/> No

YOUR CHILD AND TV

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours
If your child uses media, do you monitor the shows your child watches or activity she does?	<input type="radio"/> Yes <input type="radio"/> No

HEALTHY EATING

Do you provide a variety of vegetables, fruits, and other nutritious foods?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child eat much food that you would describe as junk food?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child drink water every day?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child willing to try new foods?	<input type="radio"/> Yes	<input type="radio"/> No

SAFETY

Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat car every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the car always use a lap and shoulder seat belt, booster seat, or car safety seat?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

18 MONTH VISIT

SAFETY (CONTINUED)

Car and Home Safety (continued)		
Do you keep your child away from the stove, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a gate at the top and bottom of all stairs in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.)	<input type="radio"/> Yes	<input type="radio"/> No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about other ways to keep your home safe?	<input type="radio"/> No	<input type="radio"/> Yes
Sun Protection		
Do you apply sunscreen on your child whenever she plays outside?	<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>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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Ages & Stages Questionnaires®

18 Month Questionnaire

17 months 0 days through 18 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 date of birth: _____ If child was born 3 or more weeks prematurely, # of weeks premature: _____ Child's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to child: Parent Guardian Teacher Child care provider
 Grandparent or other relative Foster parent Other: _____

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 #:	Age at administration in months and days:
Program ID #:	If premature, adjusted age in months and days:
Program name:	



18 Month Questionnaire

17 months 0 days
through 18 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 _____.

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, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When you ask your child to, does he go into another room to find a familiar toy or object? (<i>You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket."</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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? (<i>Mark "yes" even if her words are difficult to understand.</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (<i>He needs to identify only one picture correctly.</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (<i>Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?"</i>) Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
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="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child move around by walking, rather than by crawling on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child walk well and seldom fall?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child climb on an object such as a chair to reach something he wants (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"/>	—
5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. <i>(You can look for this at a store, on a playground, or at home.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? <i>(If your child already kicks a ball, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	GROSS MOTOR TOTAL			—


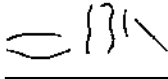



FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? <i>(If he simply drops the ball, mark "not yet" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your child stack a small block or toy on top of another one? <i>(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your child stack three small blocks or toys on top of each other by himself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your child turn the pages of a book by himself? <i>(He may turn more than one page at a time.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
	FINE MOTOR TOTAL			—



PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|--|---|-----------------------|-----------------------|------|
| 1. Does your child drop several small toys, one after another, into a container like a bowl or box? <i>(You may show him how to do it.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| 3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? <i>(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| | Count as "yes" | | | |
| |  | | | |
| | Count as "not yet" | | | |
| |  | | | |
| 5. After watching 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 <i>any direction</i> ? <i>(Mark "not yet" if your child scribbles back and forth.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? <i>(Do not show him how.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___* |

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. While looking at herself in the mirror, does your child offer a toy to her own image? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child play with a doll or stuffed animal by hugging it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your child get your attention or try to show you something by pulling on your hand or clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child drink from a cup or glass, putting it down again with little spilling? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair? | <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

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

YES

NO

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

YES

NO

4. Do you think your child walks, runs, and climbs like other toddlers her age?
If no, explain:

YES

NO

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

YES

NO

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

YES

NO

OVERALL (continued)

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

 YES NO

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

 YES NO

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

 YES NO

Child's Name _____
 Date of Birth _____
 Today's date _____

Filled out by: _____
 Relationship to child _____

M-CHAT

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

		Yes	No
1.	Does your child enjoy being swung, bounced on your knee, etc.?		
2.	Does your child take an interest in other children?		
3.	Does your child like climbing on things, such as up stairs?		
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?		
5.	Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?		
6.	Does your child ever use his/her index finger to point, to ask for something?		
7.	Does your child ever use his/her index finger to point, to indicate interest in something?		
8.	Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling, or dropping them?		
9.	Does your child ever bring objects over to you (parent) to show you something?		
10.	Does your child look you in the eye for more than a second or two?		
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)		
12.	Does your child smile in response to your face or your smile?		
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)		
14.	Does your child respond to his/her name when you call?		
15.	If you point at a toy across the room, does your child look at it?		
16.	Does your child walk?		
17.	Does your child look at things you are looking at?		
18.	Does your child make unusual finger movements near his/her face?		
19.	Does your child try to attract your attention to his/her own activity?		
20.	Have you ever wondered if your child is deaf?		
21.	Does your child understand what people say?		
21.	Does your child sometimes stare at nothing or wander with no purpose?		
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?		



18 Month ASQ-3 Information Summary

17 months 0 days through
18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

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	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	○	○	○	○	○	○	○	○

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

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