

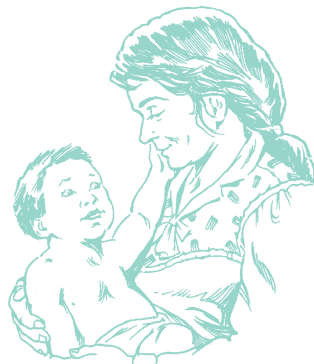
Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System **Second Edition**

By Diane Bricker and Jane Squires

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

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◆ **16 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.



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◆ **16 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: _____

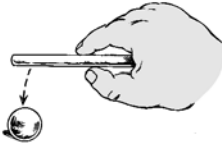


YES SOMETIMES NOT YET

FINE MOTOR *(continued)*

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|-------|
| 3. 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Does your child stack three small blocks or toys on top of each other by herself? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Does your child make a mark on the paper with the <i>tip</i> of a crayon (or pencil or pen) when trying to draw? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
|  | | | | |
| 6. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | | | FINE MOTOR TOTAL | _____ |

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

- | | | | | |
|---|--------------------------|--------------------------|------------------------------|-------|
| 1. After you scribble back and forth on paper with a crayon (or pencil or pen), does your child copy you by scribbling? (If she already scribbles on her own, check "yes" for this item.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
|  | | | | |
| 5. Without first showing him how, does your child scribble back and forth when you give him a crayon (or pencil or pen)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump it out again? (You may show her how.) | <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 help undress herself by taking off clothes like socks, hat, shoes, or mittens? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Does your child play with a doll or stuffed animal by hugging it? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

YES SOMETIMES NOT YET

PERSONAL-SOCIAL *(continued)*

4. While looking at himself in the mirror, does your child offer a toy to his own image? _____
5. Does your child get your attention or try to show you something by pulling on your hand or clothes? _____
6. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar? _____

PERSONAL-SOCIAL TOTAL _____

OVERALL *Parents and providers may use the space below or the back of this 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: _____
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: _____