

# **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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## ◆ **14 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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◆ **14 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: \_\_\_\_\_





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 say one word in addition to "Mama" and "Dada"?<br>(A "word" is a sound or sounds the baby says consistently to mean someone or something, such as "baba" for bottle.)   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When your child wants something, does she tell you by <i>pointing</i> to it?  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your child shake his head when he means "no" or "yes"?   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child point to, pat, or try to pick up pictures in a book?  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your child say four or more words in addition to "Mama" and "Dada"?  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. When you ask her 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"/> | ___ |
|  | <b>COMMUNICATION TOTAL</b> |                          |                          | ___ |

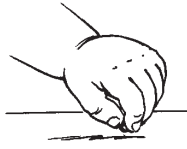
**GROSS MOTOR**      *Be sure to try each activity with your child.*

- |  |   |                          |                          |     |
|--|---|--------------------------|--------------------------|-----|
| 1. If you hold both hands just to balance him, does your child take several steps without tripping or falling? (If your child already walks alone, check "yes" for this item.) | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|  |  |                          |                          |     |
| 2. When you hold <i>one hand</i> just to balance her, does your child take several steps forward? (If your child already walks alone, check "yes" for this item.)              | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|  |  |                          |                          |     |
| 3. Does your child stand up in the middle of the floor by himself and take several steps forward?  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your child climb onto furniture?   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. 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"/> | ___ |
| 6. Does your child move around by walking, rather than by crawling on his hands and knees?   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|  | <b>GROSS MOTOR TOTAL</b>  |                          |                          | ___ |

YES      SOMETIMES      NOT YET

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

1. Without resting her arm or hand on the table, does your child pick up a crumb or Cheerio with the tip of her thumb and a finger?



                 \_\_\_\_\_

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



                 \_\_\_\_\_

3. Does your child help turn the pages of a book? (You may lift a page for her to grasp.)

                 \_\_\_\_\_

4. 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.)

                 \_\_\_\_\_

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



                 \_\_\_\_\_

6. Does your child stack three small blocks or toys on top of each other by herself?

                 \_\_\_\_\_

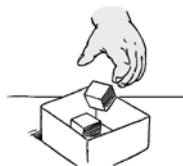
FINE MOTOR TOTAL \_\_\_\_\_

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

1. If you put a small toy into a bowl or box, does your child copy you by putting in a toy, although she may not let go of it? (If she already lets go of the toy into a bowl or box, check "yes" for this item.)

                 \_\_\_\_\_

2. Does your child drop two small toys, one after the other, into a container like a bowl or box? (You may show him how to do it.)



                 \_\_\_\_\_ \*

3. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your child copy you by scribbling? (If she already scribbles on her own, check "yes" for this item.)

                 \_\_\_\_\_

4. Can your child drop a crumb or Cheerio into a small, clear bottle (such as a plastic soda-pop bottle or baby bottle)?

                 \_\_\_\_\_

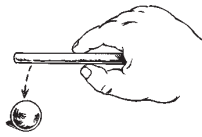
5. Does your child drop several (six or more) small toys into a container, such as a bowl or box? (You may show him how to do it.)

                 \_\_\_\_\_

YES      SOMETIMES      NOT YET

**PROBLEM-SOLVING**      *(continued)*

6. 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?



                 \_\_\_\_\_

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

*\*If problem solving item 2 is marked "yes" or "sometimes," mark problem solving item 1 as "yes."*

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

- |  |                          |                          |                          |       |
|--|--------------------------|--------------------------|--------------------------|-------|
| 1. When you dress her, does your child lift her foot for her shoe, sock, or pant leg?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Does your child roll or throw a ball back to you, so that you can return it to him?                 | <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"/> | _____ |
| 4. Does your child feed herself with a spoon, even though she may spill some food?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Does your child help undress himself by taking off clothes like socks, hat, shoes, or mittens?      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. 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"/> | _____ |

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

**OVERALL**      *Parents and providers may use the back of this sheet for additional comments.*

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Do you think your child hears well?   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____  |                              |                             |
| 2. Does your child use both hands equally well?  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____  |                              |                             |
| 3. When your child is standing, are her feet flat on the surface most of the time?       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If no, explain: _____  |                              |                             |
| 4. Does either parent have a family history of childhood deafness or hearing impairment? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____   |                              |                             |
| 5. Do you have concerns about your child's vision?                                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____   |                              |                             |
| 6. Has your child had any medical problems in the last several months?                   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____   |                              |                             |
| 7. Does anything about your child worry you?   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If yes, explain: _____   |                              |                             |