ASQ-3 Ages & Stages Questionnaires®

5 months 0 days through 6 months 30 days

6 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: | | | | | | | | | (M M D D Y Y Y Y)

Baby's information

Baby's first name: | | Middle initial: | | Baby's last name: | |

Baby's date of birth: | | (M M D D Y Y Y Y)

If baby was born 3 or more weeks prematurely, # of weeks premature: | |

Baby's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: | | Middle initial: | | Last name: | |

Street address: | |

Relationship to baby: ◯ 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

Baby ID #: | |

Program ID #: | |

Program name: | |

Age at administration, in months and days: | | | (M M D D)

If premature, adjusted age, in months and days: | | | (M M D D)

E101060100

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6 Month Questionnaire

5 months 0 days through 6 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

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

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make high-pitched squeals?	◯	◯	◯	____
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	◯	◯	◯	____
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	◯	◯	◯	____
4. When a loud noise occurs, does your baby turn to see where the sound came from?	◯	◯	◯	____
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	◯	◯	◯	____
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	◯	◯	◯	____

COMMUNICATION TOTAL ____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	◯	◯	◯	____
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	◯	◯	◯	____
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	◯	◯	◯	____
4. When you put your baby on the floor, does she lean on her hands while sitting? *(If she already sits up straight without leaning on her hands, mark "yes" for this item.)* 	◯	◯	◯	____

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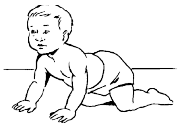
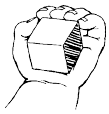
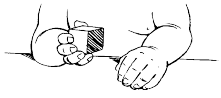
GROSS MOTOR *(continued)*

		YES	SOMETIMES	NOT YET	
5. If you hold both hands just to balance your baby, does he support his own weight while standing?		○	○	○	___
6. Does your baby get into a crawling position by getting up on her hands and knees?		○	○	○	___
			GROSS MOTOR TOTAL		___

FINE MOTOR

		YES	SOMETIMES	NOT YET	
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?		○	○	○	___
2. Does your baby reach for or grasp a toy using both hands at once?		○	○	○	___
3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? *(If he already picks up a small object the size of a pea, mark "yes" for this item.)*		○	○	○	___
4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?		○	○	○	___
5. Does your baby *try* to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? *(If he already picks up the crumb or Cheerio, mark "yes" for this item.)*		○	○	○	___
6. Does your baby pick up a small toy with only one hand?		○	○	○	___
			FINE MOTOR TOTAL		___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When a toy is in front of your baby, does she reach for it with both hands?	○	○	○	___
2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*	○	○	○	___
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___
				___

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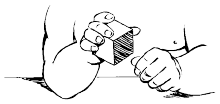
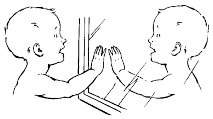
PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth? 	○	○	○	___
5. Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	___
6. Does your baby play by banging a toy up and down on the floor or table? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When in front of a large mirror, does your baby smile or coo at herself? 	○	○	○	___
2. Does your baby act differently toward strangers than he does with you and other familiar people? *(Reactions to strangers may include staring, frowning, withdrawing, or crying.)*	○	○	○	___
3. While lying on her back, does your baby play by grabbing her foot? 	○	○	○	___
4. When in front of a large mirror, does your baby reach out to pat the mirror? 	○	○	○	___
5. While your baby is on his back, does he put his foot in his mouth? 	○	○	○	___
6. Does your baby try to get a toy that is out of reach? *(She may roll, pivot on her tummy, or crawl to get it.)*	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

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OVERALL

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

1. Does your baby use both hands and both legs equally well? If no, explain: ◯ YES ◯ NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: ◯ YES ◯ NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: ◯ YES ◯ NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

5. Do you have concerns about your baby's vision? If yes, explain: ◯ YES ◯ NO

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6. Has your baby had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

7. Do you have any concerns about your baby's behavior? If yes, explain: ◯ YES ◯ NO

8. Does anything about your baby worry you? If yes, explain: ◯ YES ◯ NO

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