Ages & S Question					Alexand Street
8 Month Questi					
Please provide the following information. Use black or legibly when completing this form.	blue ink on	ly and print			
Date ASQ completed: Baby's information					
Baby's first name:	Middle initial:	E	3aby's last name:		
Baby's date of birth:		If baby was born 3 or more weeks prematurely, # of weeks premature:		Baby's gend Male	er: O Female
Person filling out questionnaire					
First name:	Middle initial:	l	_ast name:		
Street address:			Relationship to bab Parent Grandparent or other	y: Guardian Foster parent	 Teacher Child care provider Other:
<u>City:</u>	State/ Provinc		relative	ZIP/ Postal code:	
Country:	Home telepho numbe	ione		Other telephone number:	
E-mail address:					
Names of people assisting in questionnaire completion:					
Program Information					
Baby ID #:			Age at adn	ninistration in mo	onths and days:
Program ID #:			lf prematur	e, adjusted age	in months and days:
Program name:					



8 Month Questionnaire

YES

YES

7 months 0 days through 8 months 30 days

NOT YFT

NOT YET

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.

Im	portant Points to Remember:	Notes:
⊻	Try each activity with your baby before marking a response.	
ন্	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	

COMMUNICATION

- 1. If you call to your baby when you are out of sight, does she look in the direction of your voice?
- 2. When a loud noise occurs, does your baby turn to see where the sound came from?
- 3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?
- 4. Does your baby make sounds like "da," "ga," "ka," and "ba"?
- 5. Does your baby respond to the tone of your voice and stop his activity at least briefly when you say "no-no" to him?
- 6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)

GROSS MOTOR

1. 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.)



2. Does your baby roll from his back to his tummy, getting both arms out from under him?

\bigcirc	\bigcirc	\bigcirc	
\bigcirc	\bigcirc	\bigcirc	
\bigcirc	\bigcirc	\bigcirc	
0 0	0 0	\bigcirc	
\bigcirc	\bigcirc	\bigcirc	

COMMUNICATION TOTAL

SOMETIMES

SOMETIMES

	AS	iO ³
_		

*

GROSS MOTOR (continued)	YES	SOMETIMES	NOT YET	
 Does your baby get into a crawling position by get- ting up on her hands and knees? 	\bigcirc	\bigcirc	\bigcirc	
 If you hold both hands just to balance your baby, does he support his own weight while standing? 	0	\bigcirc	\bigcirc	
5. When sitting on the floor, does your baby sit up straight for several minutes <i>without</i> using her hands for support?	\bigcirc	\bigcirc	\bigcirc	
6. When you stand your baby next to furniture or the crib rail, does he hold on without leaning his chest against the furniture for support?	0	GROSS MOTO *If Gross Motor Item 5 "yes" or "sometir Gross Motor Ite	ō is marked nes," mark	
FINE MOTOR	YES	SOMETIMES	NOT YET	
 Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? (If she already picks up a small object, mark "yes" for this item.) 	\bigcirc	\bigcirc	\bigcirc	
2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?	\bigcirc	\bigcirc	\bigcirc	
3. Does your baby try to pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion, even if she isn't able to pick it up? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)	\bigcirc	\bigcirc	\bigcirc	
4. Does your baby pick up a small toy with only one hand?	\bigcirc	\bigcirc	\bigcirc	

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NOT YET

ASQ'3

FINE MOTOR (continued)

5. Does your baby *successfully* pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion? (*If he already picks up a crumb or Cheerio, mark "yes" for this item.*)



YES

6. Does your baby pick up a small toy with the *tips* of her thumb and fingers? (You should see a space between the toy and her palm.)



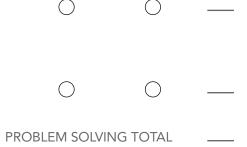
\bigcirc	\bigcirc	\bigcirc	
\bigcirc	\bigcirc	\bigcirc	*
	FINE MOTO *If Fine Motor Item "yes" or "somet Fine Motor It	6 is marked imes," mark	
YES	SOMETIMES	NOT YET	
\bigcirc	\bigcirc	\bigcirc	
\bigcirc	\bigcirc	\bigcirc	

SOMETIMES

PROBLEM SOLVING

- 1. Does your baby pick up a toy and put it in his mouth?
- 2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?
- 3. Does your baby play by banging a toy up and down on the floor or table?
- 4. Does your baby pass a toy back and forth from one hand to the other?
- 5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?
- 6. When holding a toy in his hand, does your baby bang it against another toy on the table?





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age 5 of 6
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ASQ'3		8 Month Questionr	naire page 5 of 6
PERSONAL-SOCIAL	YES	SOMETIMES NC	DT YET
 When lying on her back, does your baby play by grabbing her foot? 	\bigcirc	\bigcirc	0 —
2. When in front of a large mirror, does your baby reach out to pat the mirror?	\bigcirc	\bigcirc	0 —
3. Does your baby try to get a toy that is out of reach? (He may roll, pivot on his tummy, or crawl to get it.)	\bigcirc	\bigcirc	0 —
4. While your baby is on her back, does she put her foot in her mouth?	\bigcirc	\bigcirc	0 —
5. Does your baby drink water, juice, or formula from a cup while you hold it?	\bigcirc	\bigcirc	0 —
6. Does your baby feed himself a cracker or a cookie?	\bigcirc	\bigcirc	0 —
		PERSONAL-SOCIAL TO	DTAL
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	O NO
 When you help your baby stand, are his feet flat on the surface most of the tir If no, explain: 	ne?) YES	O NO

ASQ3	8 Month Quest	tionnaire page 6 of 6
OVERALL (continued)		
3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:	⊖ yes	O NO
 Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:) yes	O NO
 Do you have concerns about your baby's vision? If yes, explain: 	O yes	O NO
6. Has your baby had any medical problems in the last several months? If yes, explain:	⊖ yes	O NO
 Do you have any concerns about your baby's behavior? If yes, explain: 	⊖ yes	О NO
 8. Does anything about your baby worry you? If yes, explain: 	YES	O NO



8 Month ASQ-3 Information Summary

Baby's name:	Date ASQ completed:				
Baby's ID #:	Date of birth:				
Administering program/provider:	Was age adjusted for prematurity when selecting questionnaire? O Yes O No				

 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	33.06									\bigcirc	\bigcirc	0	\bigcirc	\bigcirc	0
Gross Motor	30.61									0	0	0	0	0	0
Fine Motor	40.15											0	0	0	0
Problem Solving	36.17										0	\diamond	0	0	0
Personal-Social	35.84										0	Ó	0	0	0

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

1.	Uses both hands and both legs equally well? Comments:	Yes	NO	5.	Concerns about vision? Comments:	YES	No
2.	Feet are flat on the surface most of the time? Comments:	Yes	NO	6.	Any medical problems? Comments:	YES	No
3.	Concerns about not making sounds? Comments:	YES	No	7.	Concerns about behavior? Comments:	YES	No
4.	Family history of hearing impairment? Comments:	YES	No	8.	Other concerns? 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 baby's total score is in the i area, it is above the cutoff, and the baby's development appears to be on schedule. If the baby's total score is in the i area, it is close to the cutoff. Provide learning activities and monitor. If the baby's total score is in the i 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						