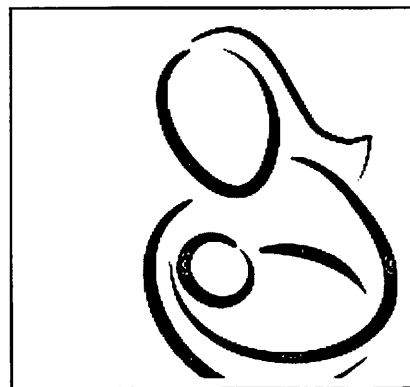


Ages & Stages Questionnaire

3 month 0 days through 4 months 30 days

4 Month Questionnaire



Date ASQ Completed: _____

Child's information

Child's first name: _____ Middle : _____ Last: _____

Child's date of birth: _____

Gender: M F

Person filling out questionnaire

First name: _____ Last name: _____

Relationship to child: Parent Grandparent Foster parent Guardian Teacher
 FOW TA Interpreter Other

Place Sticker Here

AGE CALCULATION	Year	Month	Day
Administration Date			
Date of Birth			
Age of Child			

Subtract date of birth from date ASQ-3 was administered.
See *Implementation Guide* for details.

Program Information

Name of Reach Dane site: _____

Name of classroom: _____



4 Month Questionnaire

3 months 0 days
through 4 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 chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. After you have been out of sight, does your baby smile or get excited when he sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby stop crying when she hears a voice other than yours?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby laugh?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby make sounds when looking at toys or people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. When your baby is on her tummy, does she hold her head straight up, looking around? (She can rest on her arms while doing this.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				

GROSS MOTOR (continued)

- 5. When you hold him in a sitting position, does your baby hold his head steady?
- 6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
GROSS MOTOR TOTAL			—

FINE MOTOR

- 1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)?
- 2. When you put a toy in her hand, does your baby wave it about, at least briefly?
- 3. Does your baby grab or scratch at his clothes?
- 4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?
- 5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?
- 6. When you hold your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
FINE MOTOR TOTAL			—

PROBLEM SOLVING

- 1. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?
- 2. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes?
- 3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?
- 4. When you put a toy in her hand, does your baby look at it?
- 5. When you put a toy in his hand, does your baby put the toy in his mouth?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING (continued)

6. When you dangle a toy above your baby while she is lying on her back, does your baby wave her arms toward the toy?



YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

1. Does your baby watch his hands?



YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. When your baby has her hands together, does she play with her fingers?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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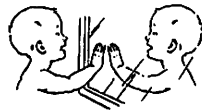
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

5. Before you smile or talk to your baby, does he smile when he sees you nearby?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. When in front of a large mirror, does your baby smile or coo at herself?



<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. 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

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 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

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



4 Month ASQ-3 Information Summary

3 months 0 days through
4 months 30 days

Baby's name: _____ Date ASQ completed: _____
 Baby'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	34.60		●	●	●	●	●	●	●	●	●	○	○	○	○
Gross Motor	38.41		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	29.62		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	34.98		●	●	●	●	●	●	●	●	●	○	○	○	○
Personal-Social	33.16		●	●	●	●	●	●	●	●	○	○	○	○	○

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 |

RESULTS/FOLLOW-UP ACTION TO BE TAKEN: Please check one.

- White dots** – when all scores fall in the white area of the score chart, no further action is needed.
- Grey dots** – will be monitored through GOLD assessment notes and individualize in lesson plans. If concerns continue with a child, contact the Disability Specialist for referral information.
- Black dots** – when a score falls in the black area, teachers are responsible to rescreen the child within 60 days of the screen date.

Other:
