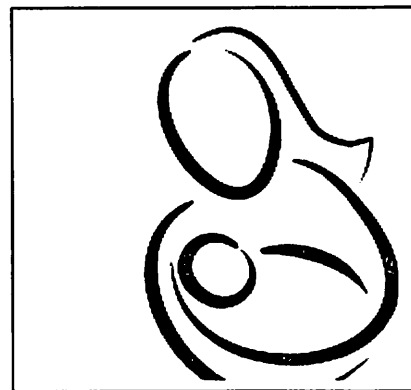


Ages & Stages Questionnaire

9 month 0 days through 9 months 30 days

9 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: _____

GROSS MOTOR

(continued)

3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?



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

4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?



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

5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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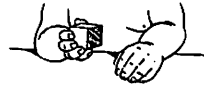
6. Does your baby walk beside furniture while holding on with only one hand?

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

GROSS MOTOR TOTAL _____

FINE MOTOR

1. Does your baby pick up a small toy with only one hand?



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

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



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

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



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

4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)



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

5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____*
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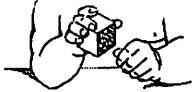


6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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FINE MOTOR TOTAL _____

*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

		YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. When holding a toy in his hand, does your baby bang it against another toy on the table?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PROBLEM SOLVING TOTAL					—

PERSONAL-SOCIAL

		YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby drink water, juice, or formula from a cup while you hold it?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby feed himself a cracker or a cookie?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?		<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

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

OVERALL (continued)

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



9 Month ASQ-3 Information Summary

9 months 0 days through
9 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	13.97		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	17.82		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	31.32		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	28.72		●	●	●	●	●	●	●	●	○	○	○	○	○
Personal-Social	18.91		●	●	●	●	●	●	○	○	○	○	○	○	○

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:
