ASQ-3

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: _____

Baby's Information

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

Baby's date of birth: _____

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 #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

P101060100

ASQ-3

6 Month Questionnaire

5 months 0 days through 6 months 30 days

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 ___

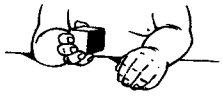
GROSS MOTOR

	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.)* 	○	○	○	___

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				___

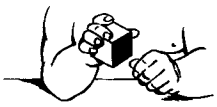
FINE MOTOR

	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

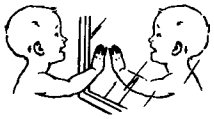
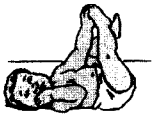
	YES	SOMETIMES	NOT YET	
1. When a toy is in front of your baby, does she reach for it with both hands?	○	○	○	___
2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*	○	○	○	___
3. When your baby is on her back,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

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 ___

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

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

ASQ-3 6 Month ASQ-3 Information Summary

5 months 0 days through 6 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	29.65		●	●	●	●	●	●	●	●	◯	◯	◯	◯	◯
Gross Motor	22.25		●	●	●	●	●	●	●	◯	◯	◯	◯	◯	◯
Fine Motor	25.14		●	●	●	●	●	●	●	●	◯	◯	◯	◯	◯
Problem Solving	27.72		●	●	●	●	●	●	●	●	◯	◯	◯	◯	◯
Personal-Social	25.34		●	●	●	●	●	●	●	●	◯	◯	◯	◯	◯

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? Yes **NO**
   Comments:
2. Feet are flat on the surface most of the time? Yes **NO**
   Comments:
3. Concerns about not making sounds? **YES** No
   Comments:
4. Family history of hearing impairment? **YES** No
   Comments:
5. Concerns about vision? **YES** No
   Comments:
6. Any medical problems? **YES** No
   Comments:
7. Concerns about behavior? **YES** No
   Comments:
8. Other concerns? **YES** No
   Comments:

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 ▭ 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 ▬ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the ■ 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						

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