



Ages & Stages Questionnaires®



4 Month Questionnaire 3 months 0 days through 4 months 30 days

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 #:

Age at administration, in months and days:

M M D D

Program ID #:

If premature, adjusted age, in months and days:

M M D D

Program name:



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)*

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-------|
| 5. When you hold him in a sitting position, does your baby hold his head steady? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |



GROSS MOTOR TOTAL

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-------|
| 1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 2. When you put a toy in her hand, does your baby wave it about, at least briefly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 3. Does your baby grab or scratch at his clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |



FINE MOTOR TOTAL

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-------|
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 4. When you put a toy in her hand, does your baby look at it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 5. When you put a toy in his hand, does your baby put the toy in his mouth? | <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

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

1. Does your baby watch his hands?



YES SOMETIMES NOT YET

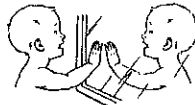
2. When your baby has her hands together, does she play with her fingers?

3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?

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?

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

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



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 |

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						