



Ages & Stages Questionnaires®

6 Month Questionnaire

5 months 0 days through 6 months 30 days



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: _____



6 Month Questionnaire

5 months 0 days
through 6 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 make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___


COMMUNICATION TOTAL _____

GROSS MOTOR




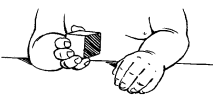
	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you put your baby on the floor, does she lean on her hands while sitting? <i>(If she already sits up straight without leaning on her hands, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby get into a crawling position by getting up on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
				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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby reach for or grasp a toy using both hands at once?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
				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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

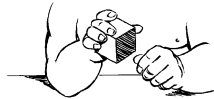
PROBLEM SOLVING (continued)

4. Does your baby pick up a toy and put it in his mouth?



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

5. Does your baby pass a toy back and forth from one hand to the other?



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

6. Does your baby play by banging a toy up and down on the floor or table?

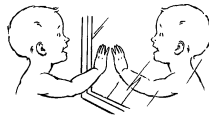


YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

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



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

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.)

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

3. While lying on her back, does your baby play by grabbing her foot?



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

4. When in front of a large mirror, does your baby reach out to pat the mirror?



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

5. While your baby is on his back, does he put his foot in his mouth?



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

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.)

YES	SOMETIMES	NOT YET	
<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

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



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?
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						