ASQ-3 Ages & Stages Questionnaires®

7 months 0 days through 8 months 30 days

8 Month Questionnaire

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:

E101080100

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ASQ-3™

8 Month Questionnaire

7 months 0 days through 8 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. If you call to your baby when you are out of sight, does she look in the direction of your voice?	○	○	○	___
2. When a loud noise occurs, does your baby turn to see where the sound came from?	○	○	○	___
3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___
4. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	___
5. Does your baby respond to the tone of your voice and stop his activity at least briefly when you say "no-no" to him?	○	○	○	___
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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.)*	○	○	○	___
2. Does your baby roll from his back to his tummy, getting both arms out from under him?	○	○	○	___

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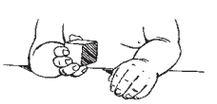
GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
3. Does your baby get into a crawling position by getting up on her hands and knees?	○	○	○	____
4. If you hold both hands just to balance your baby, does he support his own weight while standing?	○	○	○	____
5. When sitting on the floor, does your baby sit up straight for several minutes *without* using her hands for support?	○	○	○	____ *
6. When you stand your baby next to furniture or the crib rail, does he hold on without leaning his chest against the furniture for support?	○	○	○	____

GROSS MOTOR TOTAL ____

**If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."*

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? *(If she already picks up a small object, mark "yes" for this item.)*	○	○	○	____
2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?	○	○	○	____
3. Does your baby *try* to pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion, even if she isn't able to pick it up? *(If she already picks up a crumb or Cheerio, mark "yes" for this item.)*	○	○	○	____
4. Does your baby pick up a small toy with only one hand? 	○	○	○	____

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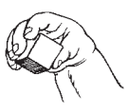
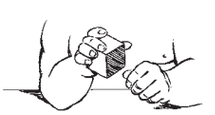
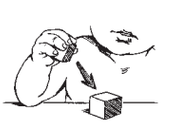
FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. Does your baby ***successfully*** pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion? *(If he already picks up a crumb or Cheerio, mark "yes" for this item.)*	○	○	○	___
6. Does your baby pick up a small toy with the ***tips*** of her thumb and fingers? *(You should see a space between the toy and her palm.)* 	○	○	○	___ *
			FINE MOTOR TOTAL	___

**If Fine Motor Item 6 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a toy and put it in his mouth?	○	○	○	___
2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___
3. Does your baby play by banging a toy up and down on the floor or table?	○	○	○	___
4. Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	___
5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?	○	○	○	___
6. When holding a toy in his hand, does your baby bang it against another toy on the table? 	○	○	○	___
			PROBLEM SOLVING TOTAL	___

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PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When lying on her back, does your baby play by grabbing her foot?	◯	◯	◯	___
2. When in front of a large mirror, does your baby reach out to pat the mirror?	◯	◯	◯	___
3. Does your baby try to get a toy that is out of reach? *(He may roll, pivot on his tummy, or crawl to get it.)*	◯	◯	◯	___
4. While your baby is on her back, does she put her foot in her mouth?	◯	◯	◯	___
5. Does your baby drink water, juice, or formula from a cup while you hold it?	◯	◯	◯	___
6. Does your baby feed himself a cracker or a cookie?	◯	◯	◯	___

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

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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

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