





YES      SOMETIMES      NOT YET

**COMMUNICATION**      *Be sure to try each activity with your child.*

- |  |                            |                          |                          |   |
|--|----------------------------|--------------------------|--------------------------|---|
| 1. Does your baby make sounds like "da," "ga," "ka," and "ba"?   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (He may say these sounds without referring to any particular object or person.)                         | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 4. If you ask her to, does your baby play at least one nursery game even if you don't show her the activity yourself (e.g., "bye-bye," "Peekaboo," "clap your hands," "So Big")?     | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," <i>without</i> your using gestures?   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 6. Does your baby say one word in addition to "Mama" and "Dada"? (A "word" is a sound or sounds the baby says consistently to mean someone or something, such as "baba" for bottle.) | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | — |
|  | <b>COMMUNICATION TOTAL</b> |                          |                          | — |






**GROSS MOTOR**      *Be sure to try each activity with your child.*

- |   |   |                          |                          |                          |   |
|---|---|--------------------------|--------------------------|--------------------------|---|
| 1. If you hold both hands just to balance her, does your baby support her own weight while standing?  |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 2. When sitting on the floor, does your baby sit up straight for several minutes <i>without</i> using his hands for support?                  |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 3. When you stand her next to furniture or the crib rail, does your baby hold on without leaning her chest against the furniture for support? |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?                                |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 6. Does your baby walk along furniture while holding on with only one hand?   |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
|   | <b>GROSS MOTOR TOTAL</b>  |                          |                          |                          | — |

YES      SOMETIMES      NOT YET

**FINE MOTOR**

*Be sure to try each activity with your child.*




- |  |  |                          |                          |                          |     |
|--|--|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your baby pick up small toys with only one hand?   |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | —   |
| 2. Does your baby <i>successfully</i> pick up a crumb or Cheerio by using her thumb and all her fingers in a raking motion? (If she already picks up a crumb or Cheerio, check "yes" for this item.) |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | —   |
| 3. Does your baby pick up a small toy with the <i>tips</i> of his thumb and fingers? (You should see a space between the toy and his palm.)  |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | —   |
| 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | —   |
| 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="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — * |
| 6. Does your baby set a small toy down, without dropping it, and then take her hand off the toy?   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | —   |

FINE MOTOR TOTAL

*\*If fine motor item 5 is marked "yes" or "sometimes," mark fine motor item 2 as "yes."*

**PROBLEM SOLVING**

*Be sure to try each activity with your child.*

- |   |   |                          |                          |                          |   |
|---|---|--------------------------|--------------------------|--------------------------|---|
| 1. Does your baby pass a toy back and forth from one hand to the other?                               |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?    |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 3. When holding a toy in his hand, does your baby bang it against another toy on the table?           |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |
| 4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")? |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | — |

YES      SOMETIMES      NOT YET

**PROBLEM SOLVING**      *(continued)*

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)?                        \_\_\_\_\_
6. After he watches you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)                        \_\_\_\_\_

PROBLEM SOLVING TOTAL      \_\_\_\_\_

**PERSONAL-SOCIAL**      *Be sure to try each activity with your child.*



1. While on her back, does your baby put her foot in her mouth?                        \_\_\_\_\_
2. Does your baby drink water, juice, or formula from a cup while you hold it?                        \_\_\_\_\_
3. Does your baby feed himself a cracker or a cookie?                        \_\_\_\_\_
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, check "yes" for this item.)                        \_\_\_\_\_
5. When you dress him, does your baby push his arm through a sleeve once his arm is started in the hole of the sleeve?                        \_\_\_\_\_
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?                        \_\_\_\_\_

PERSONAL-SOCIAL TOTAL      \_\_\_\_\_

**OVERALL**      *Parents and providers may use the bottom of the next sheet for additional comments.*

1. Do you think your child hears well?      YES       NO   
 If no, explain: \_\_\_\_\_
2. Does your baby use both hands equally well?      YES       NO   
 If no, explain: \_\_\_\_\_
3. When you help your baby stand, are his feet flat on the surface most of the time?      YES       NO   
 If no, explain: \_\_\_\_\_
4. Does either parent have a family history of childhood deafness or hearing impairment?      YES       NO   
 If yes, explain: \_\_\_\_\_

**OVERALL** (continued)

5. Do you have any concerns about your child's vision?

YES  NO

If yes, explain: \_\_\_\_\_

6. Has your child had any medical problems in the last several months?

YES  NO

If yes, explain: \_\_\_\_\_

7. Does anything about your child worry you?

YES  NO

If yes, explain: \_\_\_\_\_

# 10 Month ASQ Information Summary

Child's name: \_\_\_\_\_  
 Person filling out the ASQ: \_\_\_\_\_  
 Mailing address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Today's date: \_\_\_\_\_

Date of birth: \_\_\_\_\_  
 Corrected date of birth: \_\_\_\_\_  
 Relationship to child: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Assisting in ASQ completion: \_\_\_\_\_

**OVERALL:** Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

- |  |        |   |        |
|--|--------|---|--------|
| 1. Hears well?<br>Comments:                      | YES NO | 4. Family history of hearing impairment?<br>Comments: | YES NO |
| 2. Uses both hands equally well?<br>Comments:    | YES NO | 5. Vision concerns?<br>Comments:                      | YES NO |
| 3. Baby's feet flat on the surface?<br>Comments: | YES NO | 6. Recent medical problems?<br>Comments:              | YES NO |
|  |        | 7. Other concerns?<br>Comments:                       | YES NO |

## SCORING THE QUESTIONNAIRE

- Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide*.
- Score each item on the questionnaire by writing the appropriate number on the line by each item answer.  
 YES = 10      SOMETIMES = 5      NOT YET = 0
- Add up the item scores for each area, and record these totals in the space provided for area totals.
- Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.

Total	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross motor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine motor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem solving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-social	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total	0	5	10	15	20	25	30	35	40	45	50	55	60

Examine the blackened circles for each area in the chart above.

- If the child's total score falls within the  area, the child appears to be doing well in this area at this time.
- If the child's total score falls within the  area, talk with a professional. The child may need further evaluation.

**OPTIONAL:** The specific answers to each item on the questionnaire can be recorded below on the summary chart.

		Score Cutoff	Communication	Gross motor	Fine motor	Problem solving	Personal-social
10 months	Communication	25.0	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Gross motor	17.5	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Fine motor	39.0	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Problem solving	30.5	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Personal-social	30.0	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: \_\_\_\_\_