



# Ages & Stages Questionnaires®

## 2 Month Questionnaire

1 month 0 days through 2 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: \_\_\_\_\_



# 2 Month Questionnaire

1 month 0 days  
through 2 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 sometimes make throaty or gurgling sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When you speak to your baby, does she make sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby smile when you talk to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After you have been out of sight, does your baby smile or get excited when she sees 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 he wave his arms and legs, wiggle, and squirm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she turn her head to the side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her back, does she kick her legs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. 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"/>	___
6. 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"/>	___
			GROSS MOTOR TOTAL	___

**FINE MOTOR**

- |   | YES                   | SOMETIMES             | NOT YET               |      |
|---|-----------------------|-----------------------|-----------------------|------|
| 1. Is your baby's hand usually tightly closed when he is awake? (If your baby used to do this but no longer does, mark "yes.")    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___  |
| 2. Does your baby grasp your finger if you touch the palm of her hand?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___  |
| 3. When you put a toy in his hand, does your baby hold it in his hand briefly?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___  |
| 4. Does your baby touch her face with her hands?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___  |
| 5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___* |
| 6. Does your baby grab or scratch at her clothes?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___  |



FINE MOTOR TOTAL \_\_\_

*\*If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*


**PROBLEM SOLVING**

- |   | YES                   | SOMETIMES             | NOT YET               |     |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your baby look at objects that are 8–10 inches away?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you move around, does your baby follow you with his eyes?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. 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 her eyes, sometimes turning her head? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. 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 his eyes?                             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



PROBLEM SOLVING TOTAL \_\_\_

### PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby smile at you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you smile at your baby, does she smile back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby watch his hands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	<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. Did your baby pass the newborn hearing screening test? If no, explain:  YES     NO
2. Does your baby move both hands and both legs equally well? If no, explain:  YES     NO
3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain:  YES     NO

**OVERALL** (continued)

4. Has your baby had any medical problems? If yes, explain:

 YES NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain:

 YES NO

6. Does anything about your baby worry you? If yes, explain:

 YES NO



# 2 Month ASQ-3 Information Summary

1 months 0 days through  
2 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	22.77		●	●	●	●	●	○	○	○	○	○	○	○	○
Gross Motor	41.84		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	30.16		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	24.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	33.71		●	●	●	●	●	●	○	○	○	○	○	○	○

**2. TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |  |   |
|--|---|
| <p>1. Passed newborn hearing screening test?      Yes <b>NO</b><br/>Comments: _____</p> <p>2. Moves both hands and both legs equally well?      Yes <b>NO</b><br/>Comments: _____</p> <p>3. Family history of hearing impairment?      <b>YES</b> No<br/>Comments: _____</p> | <p>4. Any medical problems?      <b>YES</b> No<br/>Comments: _____</p> <p>5. Concerns about behavior?      <b>YES</b> No<br/>Comments: _____</p> <p>6. Other concerns?      <b>YES</b> No<br/>Comments: _____</p> |
|--|---|

**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						