



# Ages & Stages Questionnaires®

## 8 Month Questionnaire

7 months 0 days through 8 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: \_\_\_\_\_

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:

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## 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. 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"/>	_____
3. 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"/>	_____
4. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____





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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. 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"/>	_____




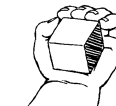


**GROSS MOTOR** (continued)

	YES	SOMETIMES	NOT YET	
3. 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"/>	_____
				
4. 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"/>	_____
				
5. When sitting on the floor, does your baby sit up straight for several minutes <i>without</i> using her hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____*
				
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				

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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
3. Does your baby <i>try</i> 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				
4. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
				

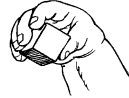
**FINE MOTOR** (continued)

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.)



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

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.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____*
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FINE MOTOR TOTAL \_\_\_\_\_

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

**PROBLEM SOLVING**

1. 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"/>	

2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?

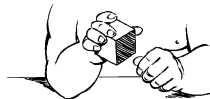
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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3. Does your baby play by banging a toy up and down on the floor or table?



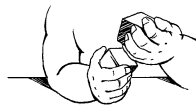
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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4. Does your baby pass a toy back and forth from one hand to the other?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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6. When holding a toy in his hand, does your baby bang it against another toy on the table?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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PROBLEM SOLVING TOTAL \_\_\_\_\_

## PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When lying on her back, does your baby play by grabbing her foot? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. When in front of a large mirror, does your baby reach out to pat the mirror? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. While your baby is on her back, does she put her foot in her mouth? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby drink water, juice, or formula from a cup while you hold it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby feed himself a cracker or a cookie?	<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

**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



# 8 Month ASQ-3 Information Summary

7 months 0 days through  
8 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	33.06		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	30.61		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	40.15		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	36.17		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	35.84		●	●	●	●	●	●	●	○	○	○	○	○	○

**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?<br>Comments:    | Yes        | <b>NO</b> | 5. Concerns about vision?<br>Comments:   | <b>YES</b> | No |
| 2. Feet are flat on the surface most of the time?<br>Comments: | Yes        | <b>NO</b> | 6. Any medical problems?<br>Comments:    | <b>YES</b> | No |
| 3. Concerns about not making sounds?<br>Comments:              | <b>YES</b> | No        | 7. Concerns about behavior?<br>Comments: | <b>YES</b> | No |
| 4. Family history of hearing impairment?<br>Comments:          | <b>YES</b> | No        | 8. Other concerns?<br>Comments:          | <b>YES</b> | 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						