4 Month Questionnaire

On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

☑ Be sure to try each activity with your child before checking a box.
☑ Try to make completing this questionnaire a game that is fun for you and your child.
☑ Make sure your child is rested, fed, and ready to play.
☑ Please return this questionnaire by ________________.
☑ If you have any questions or concerns about your child or about this questionnaire, please call: ________________________.
☑ Look forward to filling out another questionnaire in _______ months.
Please provide the following information.

Child's name: ________________________________

Child's date of birth: __________________________

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

______________________________________________________________________________________

Today's date: ________________________________

Person filling out this questionnaire: __________________________

What is your relationship to the child? __________________________

Your telephone: ____________________________

Your mailing address: __________________________

______________________________________________________________________________________

City: ____________________________

State: ____________________________ ZIP code: ____________________________

List people assisting in questionnaire completion:

______________________________________________________________________________________

Administering program or provider: __________________________

ASQ™
## Communication

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

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### Gross Motor

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

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### Fine Motor

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

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FINE MOTOR  (continued)

4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?  

5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?  

6. When you hold her in a sitting position, does your baby reach for a toy on a table close by, even though her hand may not touch it?  

FINE MOTOR TOTAL  

PROBLEM SOLVING   Be sure to try each activity with your child.

1. When you move a toy slowly from side to side in front of his face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?  

2. When you move a small toy up and down slowly in front of her face (about 10 inches away), does your baby follow the toy with her eyes?  

3. When you hold him in a sitting position, does your baby look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?  

4. When you put a toy in her hand, does your baby look at it?  

5. When you put a toy in his hand, does your baby put the toy in his mouth?  

6. When you dangle a toy above her while she is lying on her back, does your baby wave her arms toward the toy?  

PROBLEM SOLVING TOTAL  

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

1. Does your baby watch his hands?  

2. When she has her hands together, does your baby play with her fingers?  

3. When he sees the breast or bottle, does your baby know he is about to be fed?  

4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?
PERSONAL-SOCIAL (continued)

5. Before you smile or talk to him, does your baby smile when he sees you nearby?  

   YES  SOMETIMES  NOT YET
   □  □  □

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

   YES  SOMETIMES  NOT YET
   □  □  □

PERSONAL-SOCIAL TOTAL

OVERALL  Parents and providers may use the space below or the back of this sheet for additional comments.

1. Do you think your child hears well?  
   If no, explain: ____________________________
   YES  NO

2. Does your baby use both hands equally well?  
   If no, explain: ____________________________
   YES  NO

3. When you help your baby stand, are his feet flat on the surface most of the time?  
   If no, 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 child's vision?  
   If yes, explain: ____________________________
   YES  NO

6. Has your child had any medical problems in the last several months?  
   If yes, explain: ____________________________
   YES  NO

7. Does anything about your child worry you?  
   If yes, explain: ____________________________
   YES  NO
4 Month ASQ Information Summary

Child's name: ____________________________  Date of birth: ____________________________
Person filling out the ASQ: ____________________  Corrected date of birth: ____________________
Mailing address: ____________________________  Relationship to child: ____________________________
Telephone: ____________________________  City: __________________ State: _______ zip: _______
Today's date: ____________________________  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?  YES  NO
   Comments:
2. Uses both hands equally well?  YES  NO
   Comments:
3. Baby's feet flat on the surface?  YES  NO
   Comments:
4. Family history of hearing impairment?  YES  NO
   Comments:
5. Vision concerns?  YES  NO
   Comments:
6. Recent medical problems?  YES  NO
   Comments:
7. Other concerns?  YES  NO
   Comments:

SCORING THE QUESTIONNAIRE

1. 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.
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10  SOMETIME = 5  NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. 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.

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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.
5. If the child's total score falls within the □ area, the child appears to be doing well in this area at this time.
6. 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.

<table>
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<th>Score</th>
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Administering program or provider: