

**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System**  
**Second Edition**

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

Copyright © 1999 by Paul H. Brookes Publishing Co.

◆ **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.



**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System**  
**Second Edition**

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

Copyright © 1999 by Paul H. Brookes Publishing Co.

◆ **4 Month** ◆  
**Questionnaire**

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: \_\_\_\_\_






YES      SOMETIMES      NOT YET

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

- |                                                                                   |                          |                          |                          |     |
|-----------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your baby chuckle softly?                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. After you have been out of sight, does your baby stop crying when he sees you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your baby stop crying when she hears a voice other than yours?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your baby make high-pitched squeals?                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your baby laugh?                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. Does your baby make sounds when looking at toys or people?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |


COMMUNICATION TOTAL      \_\_\_

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

- |                                                                                                                                               |                                                                                     |                          |                          |     |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------|--------------------------|-----|
| 1. While on his back, does your baby move his head from side to side?                                                                         | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. 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="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. When he is on his tummy, does your baby hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?        | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                                                                                                                                               |  |                          |                          |     |
| 4. When she is on her tummy, does your baby hold her head straight up, looking around? (She can rest on her arms while doing this.)           | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                                                                                                                                               |  |                          |                          |     |
| 5. When you hold him in a sitting position, does your baby hold his head steady?                                                              | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. While on her back, does your baby bring her hands together over her chest, touching her fingers?                                           | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                                                                                                                                               |  |                          |                          |     |

GROSS MOTOR TOTAL      \_\_\_

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

- |                                                                                                                  |                                                                                     |                          |                          |     |
|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------|--------------------------|-----|
| 1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                                                                                                                  |  |                          |                          |     |
| 2. When you put a toy in her hand, does your baby wave it about, at least briefly?                               | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your baby grab or scratch at his clothes?                                                                | <input type="checkbox"/>                                                            | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

YES      SOMETIMES      NOT YET

**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?                        \_\_\_\_\_



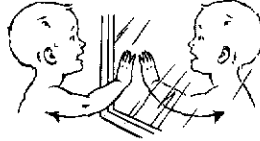
YES      SOMETIMES      NOT YET

**PERSONAL-SOCIAL**      *(continued)*

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

                 \_\_\_\_\_

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



                 \_\_\_\_\_

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?      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: \_\_\_\_\_

5. Do you have 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: \_\_\_\_\_

# 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? Comments:	YES NO	4. Family history of hearing impairment? Comments:	YES NO
2. Uses both hands equally well? Comments:	YES NO	5. Vision concerns? Comments:	YES NO
3. Baby's feet flat on the surface? Comments:	YES NO	6. Recent medical problems? Comments:	YES NO
		7. Other concerns? 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
4 months	Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gross motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fine motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Personal-social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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