

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

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◆ **6 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.



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◆ **6 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 make high-pitched squeals? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. If you call your baby when you are out of sight, does she look in the direction of your voice? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. When a loud noise occurs, does your baby turn to see where the sound came from? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your baby make sounds like "da," "ga," "ka," and "ba"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. If you copy the sounds your baby makes, does your baby repeat the sounds back to you? | <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 lift his legs high enough to see his feet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When she is on her tummy, does your baby straighten both arms and push her whole chest off the bed or floor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your baby roll from his back to his tummy, getting both arms out from under him? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. When you put her on the floor, does your baby lean on her hands while sitting? (If she already sits up straight without leaning on her hands, check "yes" for this item.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |



- | | | | | |
|--|--------------------------|--------------------------|--------------------------|-----|
| 5. If you hold both hands just to balance him, does your baby support his own weight while standing? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|--|--------------------------|--------------------------|--------------------------|-----|



- | | | | | |
|--|--------------------------|--------------------------|--------------------------|-----|
| 6. Does your baby get into a crawling position by getting up on her hands and knees? | <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 grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|---|--------------------------|--------------------------|--------------------------|-----|

YES SOMETIMES NOT YET

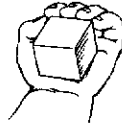
FINE MOTOR *(continued)*

2. Does your baby reach for or grasp a toy using both hands at once?

3. Does your baby reach for a crumb or Cheerio and touch it with his finger? (If he already picks up a small object the size of a pea, check "yes" for this item.)



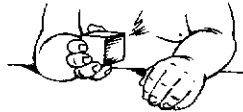
4. Does your baby pick up a small toy, holding it in the center of her hands with her fingers around it?



5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all his fingers in a raking motion, even if he isn't able to pick it up? (If he already picks up the crumb or Cheerio, check "yes" for this item.)



6. Does your baby usually pick up a small toy with only one hand?



FINE MOTOR TOTAL _____

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

1. When a toy is in front of her, does your baby reach for it with both hands?

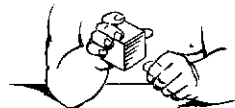
2. When he is on his back, does your baby turn his head to look for a toy when he drops it? (If he already picks it up, check "yes" for this item.)

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

4. Does your baby often pick up toys and put them in his mouth?



5. Does your baby pass a toy back and forth from one hand to the other?



6. Does your baby play by banging a toy up and down on the floor or table?



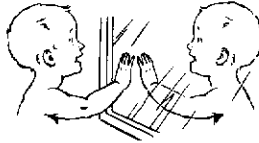
PROBLEM SOLVING TOTAL _____

YES SOMETIMES NOT YET

PERSONAL-SOCIAL

Be sure to try each activity with your child.

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



2. Does your baby act differently toward strangers than he does with you and other familiar people? (Reactions to strangers may include staring, frowning, withdrawing, or crying.)

3. While lying on her back, does your baby play by grabbing her foot?



4. When in front of a large mirror, does your baby reach out to pat the mirror?



5. While on his back, does your baby put his foot in his mouth?



6. Does your baby try to get a toy that is out of reach? (She may roll, pivot on her tummy, or crawl to get it.)

PERSONAL-SOCIAL TOTAL _____

OVERALL

Parents and providers may use 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: _____

6 Month ASQ Information Summary

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

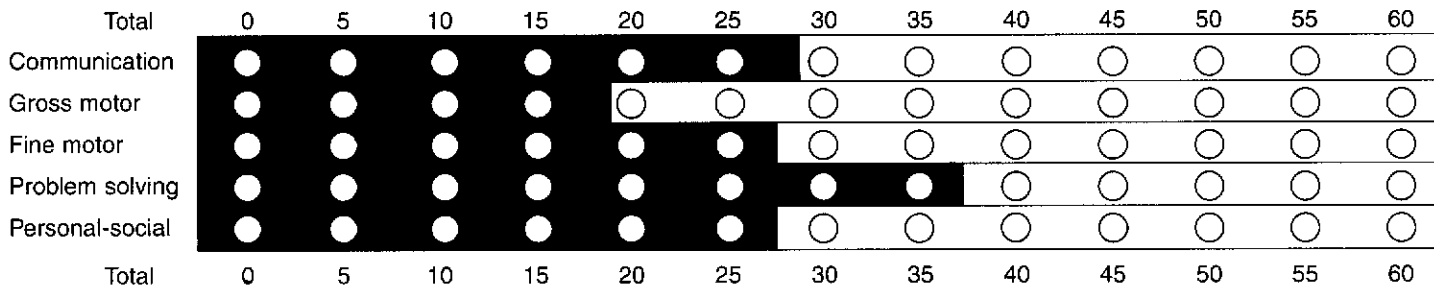
Date of birth: _____
 Corrected date of birth: _____
 Relationship to child: _____
 City: _____ State: _____ ZIP: _____
 Assisting in ASQ completion: _____

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

- | | | | |
|--|--------|---|--------|
| 1. Hears well?
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.



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
6 months	Communication	29.0	1 2 3	1 2 3	1 2 3	1 2 3
	Gross motor	19.5	3 4 5 6	3 4 5 6	3 4 5 6	3 4 5 6
	Fine motor	27.5	4 5 6	4 5 6	4 5 6	4 5 6
	Problem solving	37.0	5 6	5 6	5 6	5 6
	Personal-social	27.5	6	6	6	6
			Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____