ASQ-3 Ages & Stages Questionnaires®

1 month 0 days through 2 months 30 days

2 Month Questionnaire

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: _____

Relationship to baby:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

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: _____

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Bright Futures Parent Supplemental Questionnaire 2 Month Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please circle Yes or No for each question. Thank you.

How You Are Feeling: Parental Well-being

Are you getting enough rest?		Yes	No
Have you been out of the house without your baby?		Yes	No
Do you have someone who you can trust to look after your baby?		Yes	No
Do other family members and friends help you take care of your baby?		Yes	No
Do you and your partner spend time together?		Yes	No
Are you able to spend time alone with your older children?	N/A	Yes	No
Have you had a post-birth checkup?		Yes	No

Your Growing Baby: Infant Behavior

Do you enjoy caring for your baby?	Yes	No
Do you cuddle, talk, and play with your baby?	Yes	No
Does your baby have a regular schedule for naps and sleeping?	Yes	No
Can your baby sleep for 4–5 hours at night?	Yes	No
Does your baby sleep on his back?	Yes	No
Does your baby sleep in a crib?	Yes	No
Does your baby spend time with you on her tummy when awake?	Yes	No
Are you able to calm your baby?	Yes	No
Can you tell what your baby wants by how he cries?	Yes	No
How many hours per day does your baby watch TV?	_____ hours	

Your Baby and Family: Infant-Family Synchrony

Do you feel comfortable leaving your baby with someone else?	Yes	No
If you plan on returning to school or work, have you found child care?	Yes	No

Feeding Your Baby: Nutritional Adequacy

Can you tell when your baby is hungry?		Yes	No
Can you tell when your baby is full?		Yes	No
What are you feeding your baby?	Breast Milk	Formula	Both
Do you have any questions about pumping and storing breast milk?		No	Yes
Do you have a feeding routine?		Yes	No

Safety

Do you always use a car safety seat?	Yes	No
Is your baby's car safety seat always rear-facing in the back seat of the car?	Yes	No
Are you having any problems with your car safety seat?	No	Yes
Are your home and car smoke free?	Yes	No
Does anyone smoke around your child?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No
Do you always keep one hand on your baby when changing her diaper?	Yes	No
Is your hot water temperature at or below 120°F at the faucet?	Yes	No
Do you keep plastic bags and latex balloons away from your baby to prevent choking?	Yes	No
Do you ever drink or carry hot liquids when holding your baby?	No	Yes

ASQ-3™ 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?	○	○	○	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	○	○	○	___
3. When you speak to your baby, does she make sounds back to you?	○	○	○	___
4. Does your baby smile when you talk to him?	○	○	○	___
5. Does your baby chuckle softly?	○	○	○	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	○	○	○	___

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?	○	○	○	___
2. When your baby is on her tummy, does she turn her head to the side?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	○	○	○	___
4. When your baby is on her back, does she kick her legs?	○	○	○	___
5. While your baby is on his back, does he move his head from side to side?	○	○	○	___
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?	○	○	○	___

GROSS MOTOR TOTAL ___

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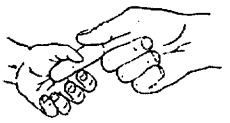
FINE MOTOR

	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.")*	○	○	○	___
2. Does your baby grasp your finger if you touch the palm of her hand? 	○	○	○	___
3. When you put a toy in his hand, does your baby hold it in his hand briefly? 	○	○	○	___
4. Does your baby touch her face with her hands?	○	○	○	___
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)? 	○	○	○	___ *
6. Does your baby grab or scratch at her clothes?	○	○	○	___

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?	○	○	○	___
2. When you move around, does your baby follow you with his eyes?	○	○	○	___
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?	○	○	○	___
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?	○	○	○	___
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?	○	○	○	___
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	○	○	○	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	○	○	○	___
3. Does your baby smile at you?	○	○	○	___
4. When you smile at your baby, does she smile back?	○	○	○	___
5. Does your baby watch his hands? 	○	○	○	___
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	○	○	○	___

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

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have copied quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

Bright Futures Parent Handout
2 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

How You Are Feeling

PARENTAL WELL-BEING

- Taking care of yourself gives you the energy to care for your baby. Remember to go for your postpartum checkup.
- Find ways to spend time alone with your partner.
- Keep in touch with family and friends.
- Give small but safe ways for your other children to help with the baby, such as bringing things you need or holding the baby's hand.
- Spend special time with each child reading, talking, or doing things together.

Your Growing Baby

INFANT BEHAVIOR

- Have simple routines each day for bathing, feeding, sleeping, and playing.
- Put your baby to sleep on her back.
  - In your room.
  - Not in your bed.
  - In a crib, with slats less than 2 3/8 inches apart.
  - With the crib's drop side always up.
  - Give your baby a pacifier.
  - Put your baby to sleep drowsy.
- Hold, talk, cuddle, read, sing, and play often with your baby. This helps build trust between you and your baby.
- Tummy time—put your baby on her tummy when awake and you are there to watch.
- Learn what things your baby does and does not like.
- Notice what helps to calm your baby such as a pacifier, fingers or thumb, or stroking, talking, rocking, or going for walks.

Safety

SAFETY

- Use a rear-facing car safety seat in the back seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your seat belt and never drive after using alcohol or drugs.
- Keep your car and home smoke free.
- Keep plastic bags, balloons, and other small objects, especially small toys from other children, away from your baby.
- Your baby can roll over, so keep a hand on your baby when dressing or changing him.
- Set the hot water heater so the temperature at the faucet is at or below 120°F.
- Never leave your baby alone in bathwater, even in a bath seat or ring.

Your Baby and Family

INFANT-FAMILY SYNCHRONY

- Start planning for when you may go back to work or school.
- Find clean, safe, and loving child care for your baby.
- Ask us for help to find things your family needs, including child care.
- Know that it is normal to feel sad leaving your baby or upset about your baby going to child care.

Feeding Your Baby

NUTRITIONAL ADEQUACY

- Feed only breast milk or iron-fortified formula in the first 4–6 months.
- Avoid feeding your baby solid foods, juice, and water until about 6 months.
- Feed your baby when your baby is hungry.
- Feed your baby when you see signs of hunger.
  - Putting hand to mouth
  - Sucking, rooting, and fussing
- End feeding when you see signs your baby is full.
  - Turning away
  - Closing the mouth
  - Relaxed arms and hands
- Burp your baby during natural feeding breaks.

If Breastfeeding

- Feed your baby 8 or more times each day.
- Plan for pumping and storing breast milk. Let us know if you need help.

If Formula Feeding

- Feed your baby 6–8 times each day.
- Make sure to prepare, heat, and store the formula safely. If you need help, ask us.
- Hold your baby so you can look at each other.
- Do not prop the bottle.

What to Expect at Your Baby's 4 Month Visit

We will talk about

- Your baby and family
- Feeding your baby
- Sleep and crib safety
- Calming your baby
- Playtime with your baby
- Caring for your baby and yourself
- Keeping your home safe for your baby
- Healthy teeth

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Parents: Staff will complete this page.

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.

1. Passed newborn hearing screening test? Yes **NO**
   Comments:

2. Moves both hands and both legs equally well? Yes **NO**
   Comments:

3. Family history of hearing impairment? **YES** No
   Comments:

4. Any medical problems? **YES** No
   Comments:

5. Concerns about behavior? **YES** No
   Comments:

6. Other concerns? **YES** No
   Comments:

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						

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