ASQ-3 Ages & Stages Questionnaires®

5 months 0 days through 6 months 30 days

6 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 6 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 Your Family Is Doing: Family Functioning

Are you and your partner getting along?	Yes	No
Is there someone who can help you with your baby?	Yes	No
How many hours per day does your baby spend in child care?	_____ hours	

Your Baby's Development: Infant Development

Does your baby watch you as you walk around the room?	Yes	No
Is your baby making eye contact with you?	Yes	No
Do you read to your baby every day?	Yes	No
Does your baby seem to get anxious or easily upset?	No	Yes
Can your baby calm herself?	Yes	No
Are you able to calm your baby?	Yes	No
Do you find activities for your baby when he is bored?	Yes	No
Do you play games with your baby, like peekaboo, or play music for him?	Yes	No
Does your baby "talk" (say things like "da," "ee," or "o")?	Yes	No
Does your baby have a regular daily schedule for feeding, napping, and playing?	Yes	No
Does your baby spend time with you on his tummy when awake?	Yes	No
Does your baby sleep for 6–8 hours at night?	Yes	No
Is your baby learning to go to sleep by herself?	Yes	No
Do you have a bedtime routine for your baby?	Yes	No
Does your baby sleep on his back?	Yes	No
Does your baby sleep in a crib?	Yes	No
How many hours per day does your baby watch TV?	_____ hours	

Feeding Your Baby: Nutrition and Feeding

What are you feeding your baby?	Breast Milk	Both	Formula

Is your baby eating solid foods?	Yes	No
Do you let your baby decide how much to eat?	Yes	No

Healthy Teeth: Oral Health

Are you using a soft toothbrush or cloth to clean your baby's teeth?	Yes	No
Do you give your baby a bottle in her crib?	No	Yes

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 in all vehicles?	Yes	No
Are you having any problems with your car safety seat?	No	Yes
Do you always stay close enough to touch your baby when he is in the bath, even if you use a bath ring?	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 have barriers around space heaters, woodstoves, or kerosene heaters?	Yes	No
Do you keep household cleaners, chemicals, and medicines locked up?	Yes	No
Does your baby ever use an infant walker?	No	Yes
Does anyone smoke around your child?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No

Bright Futures Medical Screening Questionnaire
6 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Does your child have a sibling or playmate who has or had lead poisoning?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1950?	Y	N	Unsure
Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	Y	N	Unsure
Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Is your child infected with HIV?	Y	N	Unsure
Are cavities a problem for you or anyone else in your family?	Y	N	Unsure
Does your child sleep with a bottle?	Y	N	Unsure
Does your child continuously breastfeed through the night?	Y	N	Unsure

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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

ASQ-3™ 6 Month Questionnaire

5 months 0 days through 6 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 make high-pitched squeals?	○	○	○	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	○	○	○	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	○	○	○	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	○	○	○	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	○	○	○	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	○	○	○	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	○	○	○	___
4. 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.)* 	○	○	○	___

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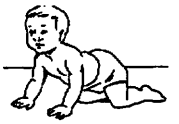
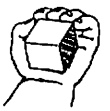
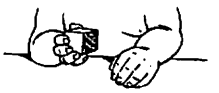
GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. If you hold both hands just to balance your baby, does he support his own weight while standing? 	○	○	○	___
6. Does your baby get into a crawling position by getting up on her hands and knees? 	○	○	○	___
GROSS MOTOR TOTAL				___

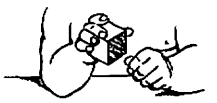
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?	○	○	○	___
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 or hand? *(If he already picks up a small object the size of a pea, mark "yes" for this item.)* 	○	○	○	___
4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it? 	○	○	○	___
5. Does your baby *try* to pick up a crumb or Cheerio by using his thumb and all of 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, mark "yes" for this item.)* 	○	○	○	___
6. Does your baby pick up a small toy with only one hand? 	○	○	○	___
FINE MOTOR TOTAL				___

PROBLEM SOLVING

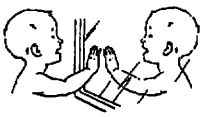
	YES	SOMETIMES	NOT YET	
1. When a toy is in front of your baby, does she reach for it with both hands?	○	○	○	___
2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*	○	○	○	___
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___
				___

PROBLEM SOLVING *(continued)*

		YES	SOMETIMES	NOT YET	
4.	Does your baby pick up a toy and put it 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 ___

PERSONAL-SOCIAL

		YES	SOMETIMES	NOT YET	
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 your baby is on his back, does he 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 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

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

Bright Futures Parent Handout
6 Month Visit

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

NUTRITION AND FEEDING

Feeding Your Baby

- Most babies have doubled their birth weight.
- Your baby's growth will slow down.
- If you are still breastfeeding, that's great! Continue as long as you both like.
- If you are formula feeding, use an iron-fortified formula.
- You may begin to feed your baby solid food when your baby is ready.
- Some of the signs your baby is ready for solids
  - Opens mouth for the spoon.
  - Sits with support.
  - Good head and neck control.
  - Interest in foods you eat.

Starting New Foods

- Introduce new foods one at a time.
  - Iron-fortified cereal
- Good sources of iron include
  - Red meat
- Introduce fruits and vegetables after your baby eats iron-fortified cereal or pureed meats well.
  - Offer 1–2 tablespoons of solid food 2–3 times per day.
- Avoid feeding your baby too much by following the baby's signs of fullness.
  - Leaning back
  - Turning away
- Do not force your baby to eat or finish foods.
  - It may take 10–15 times of giving your baby a food to try before she will like it.
- Avoid foods that can cause allergies—peanuts, tree nuts, fish, and shellfish.
- To prevent choking
  - Only give your baby very soft, small bites of finger foods.
  - Keep small objects and plastic bags away from your baby.

FAMILY FUNCTIONING

How Your Family Is Doing

- Call on others for help.
- Encourage your partner to help care for your baby.
- Ask us about helpful resources if you are alone.
- Invite friends over or join a parent group.
- Choose a mature, trained, and responsible babysitter or caregiver.
- You can talk with us about your child care choices.

ORAL HEALTH

Healthy Teeth

- Many babies begin to cut teeth.
- Use a soft cloth or toothbrush to clean each tooth with water only as it comes in.
- Ask us about the need for fluoride.
- Do not give a bottle in bed.
- Do not prop the bottle.
- Have regular times for your baby to eat. Do not let him eat all day.

INFANT DEVELOPMENT

Your Baby's Development

- Place your baby so she is sitting up and can look around.
- Talk with your baby by copying the sounds your baby makes.
- Look at and read books together.
- Play games such as peekaboo, patty-cake, and so big.
- Offer active play with mirrors, floor gyms, and colorful toys to hold.
- If your baby is fussy, give her safe toys to hold and put in her mouth and make sure she is getting regular naps and playtimes.
- Put your baby to bed when she is sleepy but still awake.

Crib/Playpen

- Lower the crib mattress all the way when your baby begins to stand.
- Use a crib with slats close together—2 3/8 inches apart or less.
- When your baby is in the crib, make sure the drop side is up.
- Don't use loose or soft bedding.
- Use a mesh playpen with weaves less than ¼ inches apart.

SAFETY

Safety

- Use a rear-facing car safety seat in the back seat in all vehicles, even for very short trips.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Don't leave your baby alone in the tub or high places such as changing tables, beds, or sofas.
- While in the kitchen, keep your baby in a high chair or playpen.
- Do not use a baby walker.
- Place gates on stairs.
- Close doors to rooms where your baby could be hurt, like the bathroom.
- Prevent burns by setting your hot water heater so the temperature at the faucet is 120°F or lower.
- Turn pot handles inward on the stove.
- Do not leave hot irons or hair care products plugged in.
- Never leave your baby alone near water or in bathwater, even in a bath seat or ring.
  - Always be close enough to touch your baby.
- Lock up poisons, medicines, and cleaning supplies; call Poison Help if your baby eats them.

What to Expect at Your Baby's 9 Month Visit

We will talk about

- Disciplining your baby
- Introducing new foods and establishing a routine
- Helping your baby learn
- Car seat safety
- Safety at home

Poison Help: 1-800-222-1222

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

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American Academy of Pediatrics
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Parents: Staff will complete this page.

6 Month ASQ-3 Information Summary

5 months 0 days through 6 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	29.65		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Gross Motor	22.25		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Fine Motor	25.14		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Problem Solving	27.72		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Personal-Social	25.34		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯

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

P101060700