

ASQ-3 Ages & Stages Questionnaires®
 3 months 0 days through 4 months 30 days
4 Month Questionnaire



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: 16072022
 M M D D Y Y Y Y

Baby's information

Baby's first name: Aurora Middle initial:

Baby's last name: Bierman

Baby's date of birth: 05272022 If baby was born 3 or more weeks prematurely, # of weeks premature:

M M D D Y Y Y Y

Baby's gender: Male Female

Person filling out questionnaire

First name: Joseph Middle initial:

Last name: Bierman

Street address: 3020 New Chapel Rd

Relationship to baby: Parent Guardian Teacher Child care provider

Grandparent or other relative Foster parent Other:

City: Jeffersonville State/Province: IN ZIP/Postal code: 47130

Country: USA Home telephone number: 5026500615 Other telephone number:

E-mail address: joebierman@yahoo.com

Names of people assisting in questionnaire completion: Joseph Bierman, Nichole Bierman

PROGRAM INFORMATION

Baby ID #:

Program ID #:

Program name:

Age at administration, in months and days: M M D D

If premature, adjusted age, in months and days: M M D D

E101040100



4 Month Questionnaire

3 months 0 days through 4 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 chuckle softly?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. After you have been out of sight, does your baby smile or get excited when he sees you?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby stop crying when she hears a voice other than yours?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your baby make high-pitched squeals?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby laugh?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby make sounds when looking at toys or people?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
COMMUNICATION TOTAL				—

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he move his head from side to side?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When your baby is on her tummy, does she hold her head straight up, looking around? (She can rest on her arms while doing this.)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	—



GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
5. When you hold him in a sitting position, does your baby hold his head steady?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
				GROSS MOTOR TOTAL



FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)?	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
3. Does your baby grab or scratch at his clothes?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
6. When you hold your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
				FINE MOTOR TOTAL



PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. 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 his eyes, sometimes turning his head?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
2. 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 her eyes?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
4. When you put a toy in her hand, does your baby look at it?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
5. When you put a toy in his hand, does your baby put the toy in his mouth?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—

PROBLEM SOLVING (continued)

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



YES	SOMETIMES	NOT YET	—
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

1. Does your baby watch his hands?



YES	SOMETIMES	NOT YET	—
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

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

<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
----------------------------------	-----------------------	-----------------------	---

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

<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
----------------------------------	-----------------------	-----------------------	---

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?

<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
----------------------------------	-----------------------	-----------------------	---

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

<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
----------------------------------	-----------------------	-----------------------	---

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



<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	—
-----------------------	----------------------------------	-----------------------	---

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:

<input checked="" type="radio"/> YES	<input type="radio"/> NO
--------------------------------------	--------------------------

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:

<input checked="" type="radio"/> YES	<input type="radio"/> NO
--------------------------------------	--------------------------

OVERALL (continued)

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

YES

NO

[Empty text box for explanation]

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

YES

NO

[Empty text box for explanation]

5. Do you have concerns about your baby's vision? If yes, explain:

YES

NO

[Empty text box for explanation]

6. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

Aurora had a sore throat 1 week ago. Mother tested positive for COVID-19, baby was not tested.

7. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

[Empty text box for explanation]

8. Does anything about your baby worry you? If yes, explain:

YES

NO

[Empty text box for explanation]



4 Month ASQ-3 Information Summary

3 months 0 days through
4 months 30 days

Baby's name: Aurora Bierman Date ASQ completed: 10/07/2022
 Baby's ID #: _____ Date of birth: 05/27/2022
 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	34.60	60	●	●	●	●	●	●	●	●	●	●	●	●	●
Gross Motor	38.41	55	●	●	●	●	●	●	●	●	●	●	●	●	●
Fine Motor	29.62	60	●	●	●	●	●	●	●	●	●	●	●	●	●
Problem Solving	34.98	55	●	●	●	●	●	●	●	●	●	●	●	●	●
Personal-Social	33.16	55	●	●	●	●	●	●	●	●	●	●	●	●	●

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- Uses both hands and both legs equally well? **Yes** NO
Comments: _____
- Concerns about vision? **YES** No
Comments: _____
- Feet are flat on the surface most of the time? **Yes** NO
Comments: _____
- Any medical problems? **YES** No
Comments: Possibly COVID-19
- Concerns about not making sounds? **YES** No
Comments: _____
- Concerns about behavior? **YES** No
Comments: _____
- Family history of hearing impairment? **YES** No
Comments: _____
- 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	Y	Y	Y	Y	Y	Y
Gross Motor	Y	Y	Y	S	Y	Y
Fine Motor	Y	Y	Y	Y	Y	Y
Problem Solving	Y	Y	Y	Y	Y	S
Personal-Social	Y	Y	Y	Y	Y	S