



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?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
3. When you speak to your baby, does she make sounds back to you?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
4. Does your baby smile when you talk to him?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
5. Does your baby chuckle softly?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	<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 wave his arms and legs, wiggle, and squirm?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she turn her head to the side?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her back, does she kick her legs?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
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?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
GROSS MOTOR TOTAL				___

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

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?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
2. When you move around, does your baby follow you with his eyes?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	___
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?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	___
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?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	___
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	___
				

PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

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

vision problems. Both are near sighted & has astigmatism.

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

Baby has painful latching.

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

 YES NO

ON and OFF rashes/redness to face. Phlegm stuck in throat. Unable to expel



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

2. Moves both hands and both legs equally well? Yes **NO** 5. Concerns about behavior? **YES** No
Comments: _____ Comments: _____

3. Family history of hearing impairment? **YES** No 6. Other concerns? **YES** No
Comments: _____ 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						