# 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: 0 3 0 4 2 0 2 6 (M M D D Y Y Y Y)

## Baby's information

Baby's first name: N O A H

Middle initial: X

Baby's last name: L E E

Baby's date of birth: 1 2 3 1 2 0 2 5 (M M D D Y Y Y Y)

If baby was born 3 or more weeks prematurely, # of weeks premature:

Baby's gender: (X) Male ( ) Female

## Person filling out questionnaire

First name: J I H E E

Middle initial:

Last name: K I M

Street address: 3 5 7 P A D D O C K D R W E S T

Relationship to baby: ( ) Parent ( ) Guardian ( ) Teacher ( ) Child care provider ( ) Grandparent or other relative ( ) Foster parent (X) Other: Family friend

City: S A V O Y

State/Province: I L

ZIP/Postal code: 6 1 8 7 4

Country: U S A

Home telephone number: 2 1 7 7 2 1 5 5 4 4

Other telephone number:

E-mail address: j i h e e 3 3 7 4 @ g m a i l . c o m

Names of people assisting in questionnaire completion: Jen Lee (Mother)

## 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

E101020100

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 ___



E101020200

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

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

PROBLEM SOLVING TOTAL ___

## PERSONAL-SOCIAL

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

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: X YES ○ NO

2. Does your baby move both hands and both legs equally well? If no, explain: X YES ○ NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: ○ YES X 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