Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By Diane Bricker and Jane Squires
with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

• 4 Month • Questionnaire

On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Be sure to try each activity with your child before checking a box.
- ☑ Try to make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested, fed, and ready to play.
- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Look forward to filling out another questionnaire in _____ months.

ASQ™

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• 4 Month • Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

_____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ™

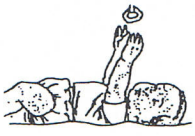
	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. Does your baby chuckle softly?	❑	❑	❑	___
2. After you have been out of sight, does your baby stop crying when he sees you?	❑	❑	❑	___
3. Does your baby stop crying when she hears a voice other than yours?	❑	❑	❑	___
4. Does your baby make high-pitched squeals?	❑	❑	❑	___
5. Does your baby laugh?	❑	❑	❑	___
6. Does your baby make sounds when looking at toys or people?	❑	❑	❑	___
		COMMUNICATION TOTAL		___
GROSS MOTOR *Be sure to try each activity with your child.*				
1. While on his back, does your baby move his head from side to side?	❑	❑	❑	___
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?	❑	❑	❑	___
3. When he is on his tummy, does your baby hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds? 	❑	❑	❑	___
4. When she is on her tummy, does your baby hold her head straight up, looking around? (She can rest on her arms while doing this.) 	❑	❑	❑	___
5. When you hold him in a sitting position, does your baby hold his head steady?	❑	❑	❑	___
6. While on her back, does your baby bring her hands together over her chest, touching her fingers? 	❑	❑	❑	___
		GROSS MOTOR TOTAL		___
FINE MOTOR *Be sure to try each activity with your child.*				
1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? 	❑	❑	❑	___
2. When you put a toy in her hand, does your baby wave it about, at least briefly?	❑	❑	❑	___
3. Does your baby grab or scratch at his clothes?	❑	❑	❑	___

	YES	SOMETIMES	NOT YET	

FINE MOTOR *(continued)*

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?	❑	❑	❑	___
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?	❑	❑	❑	___
6. When you hold her in a sitting position, does your baby reach for a toy on a table close by, even though her hand may not touch it?	❑	❑	❑	___
			FINE MOTOR TOTAL	___

PROBLEM SOLVING *Be sure to try each activity with your child.*

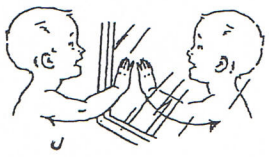
1. When you move a toy slowly from side to side in front of his face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?	❑	❑	❑	___
2. When you move a small toy up and down slowly in front of her face (about 10 inches away), does your baby follow the toy with her eyes?	❑	❑	❑	___
3. When you hold him in a sitting position, does your baby look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?	❑	❑	❑	___
4. When you put a toy in her hand, does your baby look at it?	❑	❑	❑	___
5. When you put a toy in his hand, does your baby put the toy in his mouth?	❑	❑	❑	___
6. When you dangle a toy above her while she is lying on her back, does your baby wave her arms toward the toy? 	❑	❑	❑	___
			PROBLEM SOLVING TOTAL	___

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. Does your baby watch his hands? 	❑	❑	❑	___
2. When she has her hands together, does your baby play with her fingers?	❑	❑	❑	___
3. When he sees the breast or bottle, does your baby know he is about to be fed?	❑	❑	❑	___
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?	❑	❑	❑	___

PERSONAL-SOCIAL *(continued)*

	YES	SOMETIMES	NOT YET	
5. Before you smile or talk to him, does your baby smile when he sees you nearby?	☐	☐	☐	___
6. When in front of a large mirror, does your baby smile or coo at herself?	☐	☐	☐	___



PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below or the back of this sheet for additional comments.

1. Do you think your child hears well? YES ☐ NO ☐
   If no, explain: _____
2. Does your baby use both hands equally well? YES ☐ NO ☐
   If no, explain: _____
3. When you help your baby stand, are his feet flat on the surface most of the time? YES ☐ NO ☐
   If no, explain: _____
4. Does either parent have a family history of childhood deafness or hearing impairment? YES ☐ NO ☐
   If yes, explain: _____
5. Do you have concerns about your child's vision? YES ☐ NO ☐
   If yes, explain: _____
6. Has your child had any medical problems in the last several months? YES ☐ NO ☐
   If yes, explain: _____
7. Does anything about your child worry you? YES ☐ NO ☐
   If yes, explain: _____

4 Month ASQ Information Summary

Child's name: _____ Date of birth: _____

Person filling out the ASQ: _____ Corrected date of birth: _____

Mailing address: _____ Relationship to child: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ completion: _____

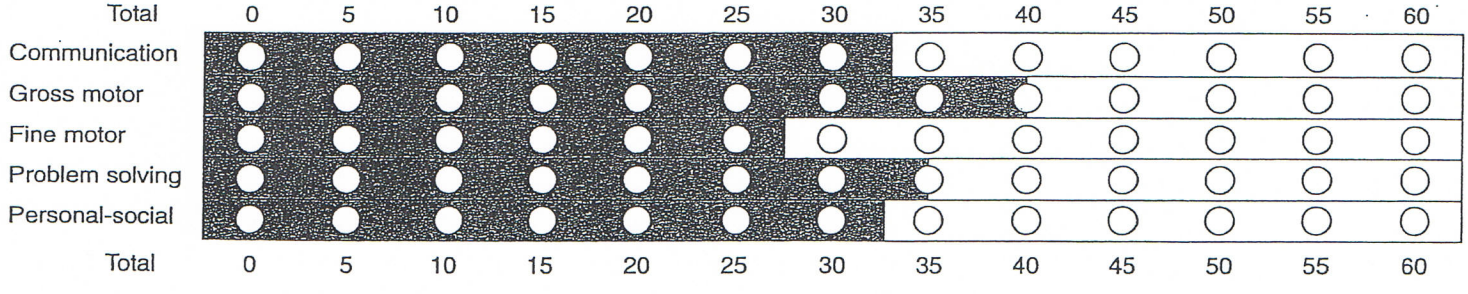
Today's date: _____ _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1. Hears well? YES NO
   Comments:
2. Uses both hands equally well? YES NO
   Comments:
3. Baby's feet flat on the surface? YES NO
   Comments:
4. Family history of hearing impairment? YES NO
   Comments:
5. Vision concerns? YES NO
   Comments:
6. Recent medical problems? YES NO
   Comments:
7. Other concerns? YES NO
   Comments:

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide.*
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the ▭ area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the ▩ area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

4 months

	Score	Cutoff
Communication		33.3
Gross motor		40.1
Fine motor		27.5
Problem solving		35.0
Personal-social		33.0

	Communication	Gross motor	Fine motor	Problem solving	Personal-social
1	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
2	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
3	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
4	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
5	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
6	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
	Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____