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***

6 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™

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***

6 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: _____

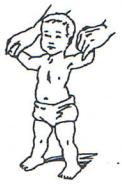
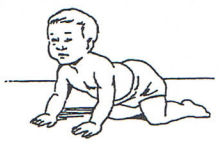
State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ™

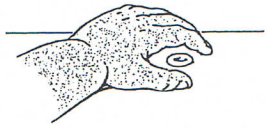
	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. Does your baby make high-pitched squeals?	❑	❑	❑	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	❑	❑	❑	___
3. If you call your baby when you are out of sight, 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 sounds back to you?	❑	❑	❑	___
		COMMUNICATION TOTAL		___
GROSS MOTOR *Be sure to try each activity with your child.*				
1. While on his back, does your baby lift his legs high enough to see his feet?	❑	❑	❑	___
2. When she is on her tummy, does your baby 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 her on the floor, does your baby lean on her hands while sitting? (If she already sits up straight without leaning on her hands, check "yes" for this item.) 	❑	❑	❑	___
5. If you hold both hands just to balance him, does your baby 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 *Be sure to try each activity with your child.*				
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?	❑	❑	❑	___

	YES	SOMETIMES	NOT YET	

FINE MOTOR *(continued)*

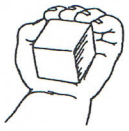
2. Does your baby reach for or grasp a toy using both hands at once? ❑ ❑ ❑ ___

3. Does your baby reach for a crumb or Cheerio and touch it with his finger? (If he already picks up a small object the size of a pea, check "yes" for this item.)



❑ ❑ ❑ ___

4. Does your baby pick up a small toy, holding it in the center of her hands with her fingers around it?

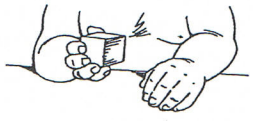


❑ ❑ ❑ ___

5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all 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, check "yes" for this item.)

❑ ❑ ❑ ___

6. Does your baby usually pick up a small toy with only one hand?



❑ ❑ ❑ ___

FINE MOTOR TOTAL ___

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

1. When a toy is in front of her, does your baby reach for it with both hands? ❑ ❑ ❑ ___

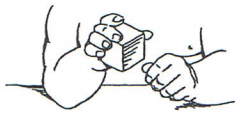
2. When he is on his back, does your baby turn his head to look for a toy when he drops it? (If he already picks it up, check "yes" for this item.) ❑ ❑ ❑ ___

3. When she is on her back, does your baby try to get a toy she has dropped if she can see it? ❑ ❑ ❑ ___

4. Does your baby often pick up toys and put them in his mouth?

❑ ❑ ❑ ___

5. Does your baby pass a toy back and forth from one hand to the other?



❑ ❑ ❑ ___

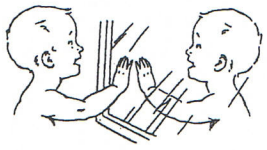
6. Does your baby play by banging a toy up and down on the floor or table?

❑ ❑ ❑ ___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

Be sure to try each activity with your child.

	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 on his back, does your baby 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 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: _____

6 Month ASQ Information Summary

Child's name: _____ Date of birth: _____

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

Mailing address: _____ Relationship to child: _____

Telephone: _____ City: _____ State: _____ ZIP: _____

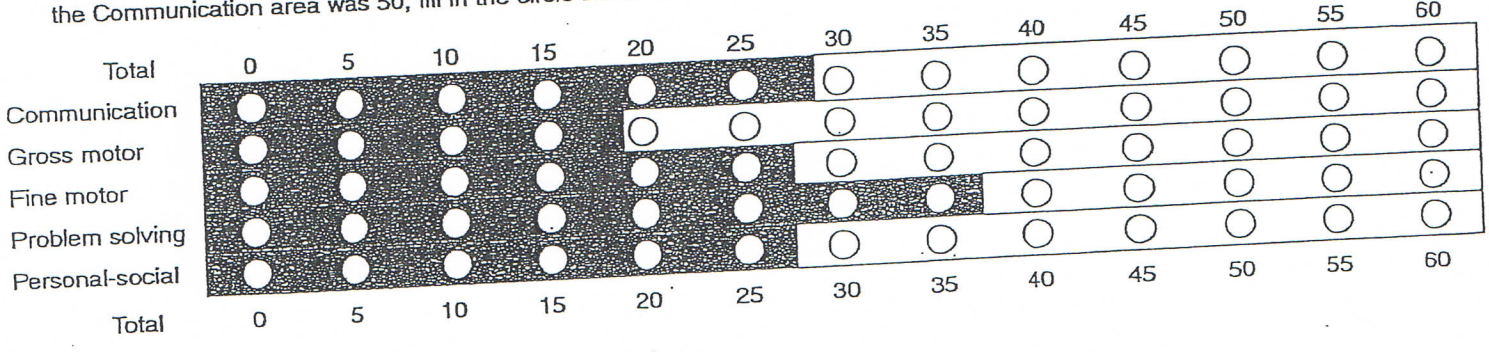
Today's date: _____ Assisting in ASQ completion: _____

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.



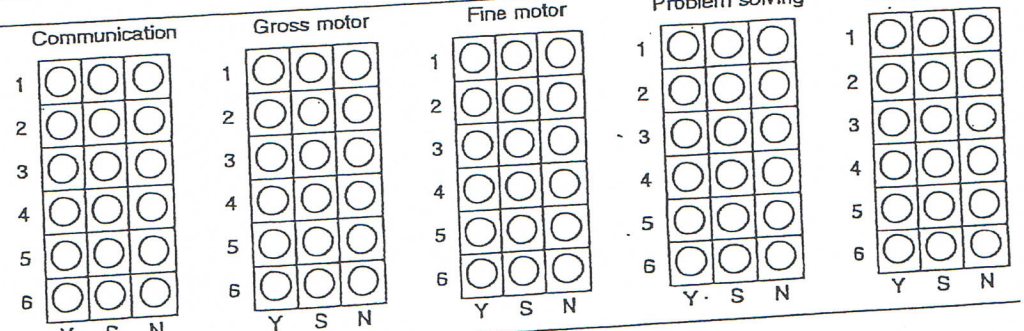
Examine the blackened circles for each area in the chart above.

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.

6 months

	Score	Cutoff
Communication		29.0
Gross motor		19.5
Fine motor		27.5
Problem solving		37.0
Personal-social		27.5



Administering program or provider: _____