Ages & Stages Questionnaires®
6 Month Questionnaire

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

Date ASQ completed:

Baby’s information

Baby’s first name: ____________________________  Middle initial: ______

Baby’s last name: ____________________________

Baby’s date of birth: _______ _______ _______ _______ _______ _______ _______

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

Baby’s gender:  ○ Male  ○ Female

Person filling out questionnaire

First name: ____________________________  Middle initial: ______

Last name: ____________________________

Street address: ____________________________

City: ____________________________  State/Province: ______  ZIP/Postal code: ______

Country: ____________________________

Home telephone number: ____________________________

Other telephone number: ____________________________

E-mail address: ____________________________

Names of people assisting in questionnaire completion: ____________________________

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

E101060100

Ages & Stages Questionnaires®, Third Edition (ASQ-3™), Squires & Bricker
© 2009 Paul H. Brookes Publishing Co. All rights reserved.
COMMUNICATION

1. Does your baby make high-pitched squeals?  
   YES  SOMETIMES  NOT YET

2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?  
   YES  SOMETIMES  NOT YET

3. If you call your baby when you are out of sight, does she look in the direction of your voice?  
   YES  SOMETIMES  NOT YET

4. When a loud noise occurs, does your baby turn to see where the sound came from?  
   YES  SOMETIMES  NOT YET

5. Does your baby make sounds like “da,” “ga,” “ka,” and “ba”?  
   YES  SOMETIMES  NOT YET

6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?  
   YES  SOMETIMES  NOT YET

COMMUNICATION TOTAL

GROSS MOTOR

1. While your baby is on his back, does your baby lift his legs high enough to see his feet?  
   YES  SOMETIMES  NOT YET

2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?  
   YES  SOMETIMES  NOT YET

3. Does your baby roll from his back to his tummy, getting both arms out from under him?  
   YES  SOMETIMES  NOT YET

4. When you put your baby on the floor, does she lean on her hands while sitting? (If she already sits up straight without leaning on her hands, mark “yes” for this item.)  
   YES  SOMETIMES  NOT YET
GROSS MOTOR (continued)

5. If you hold both hands just to balance your baby, does he support his own weight while standing?
   - YES   - SOMETIMES   - NOT YET

6. Does your baby get into a crawling position by getting up on her hands and knees?
   - YES   - SOMETIMES   - NOT YET

FINE MOTOR

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

2. Does your baby reach for or grasp a toy using both hands at once?
   - YES   - SOMETIMES   - NOT YET

3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? (If he already picks up a small object the size of a pea, mark “yes” for this item.)
   - YES   - SOMETIMES   - NOT YET

4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?
   - YES   - SOMETIMES   - NOT YET

5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of 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, mark “yes” for this item.)
   - YES   - SOMETIMES   - NOT YET

6. Does your baby pick up a small toy with only one hand?
   - YES   - SOMETIMES   - NOT YET

PROBLEM SOLVING

1. When a toy is in front of your baby, does she reach for it with both hands?
   - YES   - SOMETIMES   - NOT YET

2. When your baby is on his back, does he turn his head to look for a toy when he drops it? (If he already picks it up, mark “yes” for this item.)
   - YES   - SOMETIMES   - NOT YET

3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?
   - YES   - SOMETIMES   - NOT YET

GROSS MOTOR TOTAL

FINE MOTOR TOTAL

PROBLEM SOLVING
### Problem Solving (continued)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>Sometimes</th>
<th>Not Yet</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Does your baby pick up a toy and put it in his mouth?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does your baby pass a toy back and forth from one hand to the other?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Does your baby play by banging a toy up and down on the floor or table?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Problem Solving Total**

### Personal-Social

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>Sometimes</th>
<th>Not Yet</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When in front of a large mirror, does your baby smile or coo at herself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does your baby act differently toward strangers than he does with you and other familiar people? <em>(Reactions to strangers may include staring, frowning, withdrawing, or crying.)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. While lying on her back, does your baby play by grabbing her foot?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. When in front of a large mirror, does your baby reach out to pat the mirror?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. While your baby is on his back, does he put his foot in his mouth?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Does your baby try to get a toy that is out of reach? <em>(She may roll, pivot on her tummy, or crawl to get it.)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:  
   ○ YES  ○ NO

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

3. Do you have concerns that your baby is too quiet or does not make sounds like 
   other babies? If yes, explain:  
   ○ YES  ○ NO

4. Does either parent have a family history of childhood deafness or hearing 
   impairment? If yes, explain:  
   ○ YES  ○ NO

5. Do you have concerns about your baby’s vision? If yes, explain:  
   ○ YES  ○ NO
6. Has your baby had any medical problems in the last several months? If yes, explain:

   ○ YES  ○ NO


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

   ○ YES  ○ NO


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

   ○ 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.

<table>
<thead>
<tr>
<th>Area</th>
<th>Cutoff</th>
<th>Total Score</th>
<th>0</th>
<th>5</th>
<th>10</th>
<th>15</th>
<th>20</th>
<th>25</th>
<th>30</th>
<th>35</th>
<th>40</th>
<th>45</th>
<th>50</th>
<th>55</th>
<th>60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>29.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Motor</td>
<td>22.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor</td>
<td>25.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td>27.72</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal-Social</td>
<td>25.34</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. Transfer Overall Responses


1. Uses both hands and both legs equally well? YES No
   Comments:

2. Feet are flat on the surface most of the time? YES No
   Comments:

3. Concerns about not making sounds? YES No
   Comments:

4. Family history of hearing impairment? YES No
   Comments:

5. Concerns about vision? YES No
   Comments:

6. Any medical problems? YES No
   Comments:

7. Concerns about behavior? YES No
   Comments:

8. 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

- 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)

<table>
<thead>
<tr>
<th>Area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Motor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal-Social</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>