

# 6 Month Pre-Visit Questionnaire

**Instructions:** Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

## General Health

1	Do you have concerns about your baby?	NO	YES
2	Does your baby ever appear cross-eyed?	NO	YES
3	Has your baby had any problems with shots or immunizations?	NO	YES
4	Does your baby receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

## Feeding/Nutrition

5	Is your baby breastfeeding?	YES	NO
	a. How many times a day does your baby breastfeed?		
6	Is your baby taking (drinking) formula?	YES	NO
	a. How many ounces of formula total each day?		
	b. Which formula are you feeding your baby?		
7	Are you giving your baby any solid foods?	YES	NO
8	Is your baby taking an infant multivitamin D supplement? (If your baby is taking more than 34 ounces of formula per day, you do not need to be giving a supplement).	YES	NO

## Oral Health

9	Does your child sleep with a bottle?	NO	YES
10	Does your baby wake at night to eat?	NO	YES
11	Are you using a soft toothbrush or cloth with fluoridated toothpaste to clean your baby's teeth and gums?	YES	NO
12	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

## Elimination

13	Does your baby have any problems with bowel movements (going poop)?	NO	YES
14	Is your baby urinating (peeing) well?	YES	NO

## Sleep

15 Does your baby sleep at least 6 to 8 hours without waking up at night?	YES	NO
16 Does your baby fall asleep on his/her own?	YES	NO
17 Do you have a bedtime routine?	YES	NO

## Development

18 Babbling and imitating sounds?	YES	NO
19 Responds to his or her name?	YES	NO
20 Rolling over both ways?	YES	NO
21 Makes eye contact?	YES	NO
22 Reaches for things?	YES	NO
23 Sits unassisted for a few seconds?	YES	NO
24 Do you read to your baby every day?	YES	NO
25 Do you play games like peek-a-boo or play music with your baby?	YES	NO

## Social Stressors

26 Are you having any family stress?	NO	YES	
27 Do you feel you receive the support you need?	YES	NO	
28 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
29 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
30 Do you ever feel angry or frustrated with your baby?	NO	YES	

## Safety

31 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
32 Does your baby wear any jewelry (including necklaces)?	NO	YES
33 Do you hold or carry hot liquids around the baby?	NO	YES
34 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
35 Does anyone smoke or vape around your baby?	NO	YES
36 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO
37 Are you using a shade or sunscreen if your baby is in the sun more than 15-30 minutes?	YES	NO

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38 Do you keep plastic bags and latex balloons away from your baby?	YES	NO
39 Is your water heater turned to below 120 degrees?	YES	NO
40 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO
41 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO
42 Does your baby use a seated infant walker with wheels?	NO	YES



## Postnatal Depression

**Instructions:** Please check the box to the left of the answer that comes closest to how you have felt **in the past seven (7) days**, not just how you feel today:

1 I have been able to laugh and see the funny side of things:

- ☐ As much as I always could    ☐ Not quite so much now    ☐ Definitely not so much now    ☐ Not at all

2 I have looked forward with enjoyment to things:

- ☐ As much as I ever did    ☐ Rather less than I used to    ☐ Definitely less than I used to    ☐ Hardly at all

3 I have blamed myself unnecessarily when things went wrong:

- ☐ Yes, most of the time    ☐ Yes, some of the time    ☐ Not very often    ☐ No, never

4 I have been anxious or worried for no good reason:

- ☐ No, not at all    ☐ Hardly ever    ☐ Yes, sometimes    ☐ Yes, very often

5 I have felt scared or panicky for no good reason:

- ☐ Yes, quite a lot    ☐ Yes, sometimes    ☐ No, not much    ☐ No, not at all

6 Things have been getting to me:

- ☐ Yes, most of the time I haven't been able to cope at all    ☐ Yes, sometimes I haven't been coping as well as usual    ☐ No, most of the time I have coped quite well    ☐ No, I have been coping as well as ever

7 I have been so unhappy that I have had difficulty sleeping:

- ☐ Yes, most of the time    ☐ Yes, sometimes    ☐ No, not very much    ☐ No, not at all

8 I have felt sad or miserable:

- ☐ Yes, most of the time    ☐ Yes, quite often    ☐ Not very often    ☐ No, not at all

9 I have been so unhappy that I have been crying:

- ☐ Yes, most of the time    ☐ Yes, quite often    ☐ Only occasionally    ☐ No, never

10 The thought of harming myself has occurred to me:

- ☐ Yes, quite often    ☐ Sometimes    ☐ Hardly ever    ☐ Never



## 6 Month Questionnaire

5 months 0 days  
through 6 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:

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## COMMUNICATION

YES                      SOMETIMES                      NOT YET

- |   |                       |                       |                       |       |
|---|-----------------------|-----------------------|-----------------------|-------|
| 1. Does your baby make high-pitched squeals?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. If you call your baby when you are out of sight, does she look in the direction of your voice? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 4. When a loud noise occurs, does your baby turn to see where the sound came from?                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 5. Does your baby make sounds like "da," "ga," "ka," and "ba"?                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?     | <input 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 your baby lift his legs high enough to see his feet?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. Does your baby roll from his back to his tummy, getting both arms out from under him?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |



**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?

☐☐☐

GROSS MOTOR TOTAL

**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?

☐☐☐

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.)

☐☐☐

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

☐☐☐

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.)

☐☐☐

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

☐☐☐

FINE MOTOR TOTAL

**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.)

☐☐☐

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

☐☐☐



**PROBLEM SOLVING** (continued)

YES      SOMETIMES      NOT YET

4. Does your baby pick up a toy and put it 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**

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 your baby is on his back, does he 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 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



## 6 Month ASQ-3 Information Summary

5 months 0 days through  
6 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	29.65		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	22.25		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	25.14		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	27.72		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	25.34		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |  |            |           |  |            |    |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?<br>Comments:    | Yes        | <b>NO</b> | 5. Concerns about vision?<br>Comments:   | <b>YES</b> | No |
| 2. Feet are flat on the surface most of the time?<br>Comments: | Yes        | <b>NO</b> | 6. Any medical problems?<br>Comments:    | <b>YES</b> | No |
| 3. Concerns about not making sounds?<br>Comments:              | <b>YES</b> | No        | 7. Concerns about behavior?<br>Comments: | <b>YES</b> | No |
| 4. Family history of hearing impairment?<br>Comments:          | <b>YES</b> | No        | 8. Other concerns?<br>Comments:          | <b>YES</b> | No |

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						