

# 9 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 any concerns about your baby's health?	NO	YES
2	Has your baby had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

## Review of Systems

4	Do you have any concerns about your baby's hearing?	NO	YES
5	Do you have any concerns about your baby's vision?	NO	YES
6	Does your baby ever appear cross-eyed?	NO	YES

## Feeding/Nutrition

7	Is your child breastfeeding well?	YES	NO
	a. How many times a day does your baby breastfeed?		
8	Is your baby taking (drinking) formula?	YES	NO
	a. How many ounces of formula is your baby drinking a day?		
	b. Which formula are you feeding your baby?		
9	Is your baby getting 2-3 meals of solid foods per day?	YES	NO
10	Is your baby trying to feed him or herself?	YES	NO
11	Does your baby drink juice or other sweetened drinks?	NO	YES
12	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
13	Have you introduced common allergen foods like eggs, peanuts, tree nuts, soy, dairy, fish or shellfish into your baby's diet? (Please note these should be given in a form that your baby will not choke on such as peanut butter or pureed shellfish)	YES	NO

## Oral Health

14 Does your baby fall asleep with a bottle and/or wake at night to breast or bottle feed?	NO	YES
15 Are you using a soft toothbrush or cloth with fluoridated toothpaste to clean your baby's teeth and gums 2 times per day?	YES	NO
16 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

## Elimination

17 Does your baby have any problems with bowel movements (going poop)?	NO	YES
18 Do you have any concerns about your baby's urination (peeing)?	NO	YES

## Activity / Exercise / Screen Time

19 Does your baby have screen time (smartphone, tablet, TV)?	NO	YES
20 Do you read to your baby every day?	YES	NO
21 Does your baby get supervised floor time every day?	YES	NO

## Sleep

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

## Social Stressors

25 Do you feel you receive the support you need?	YES	NO	
26 Have there been any major changes or stresses in your family recently?	NO	YES	
27 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
28 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
29 Has anyone ever hurt you or your baby?	NO	YES	

## Lead

30 Is your baby regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
31 Does your baby have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

## Safety

32 Do you always stay close enough to touch baby when he or she is in the bath?	YES	NO	
33 Do you keep furniture away from windows or use window guards?	YES	NO	
34 Does your baby wear any jewelry (including necklaces)?	NO	YES	
35 Do you hold or carry hot liquids around the baby?	NO	YES	
36 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO	
37 Does anyone smoke or vape around your baby?	NO	YES	
38 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
39 Are you using a shade or sunscreen if your baby is in the sun more than 15-30 minutes?	YES	NO	
40 Do you keep plastic bags and latex balloons away from your baby?	YES	NO	
41 Is your water heater turned to below 120 degrees?	YES	NO	
42 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO	
43 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO	
44 Do you have the number for Poison Control?	YES	NO	
45 Does your baby use a seated infant walker?	NO	YES	
46 If there is a gun in the home, is it locked in a safe with the ammunition stored separately?	N/A	YES	NO

## Tuberculosis

47 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
48 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
49 Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
50 Has your baby traveled to a high-risk country for more than a week?	NO	YES





## 9 Month Questionnaire

9 months 0 days  
through 9 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 sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. 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"/>	—
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. If you ask your baby to, does he play at least one nursery game even if you don't show her the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

COMMUNICATION TOTAL

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## GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—



## GROSS MOTOR

*(continued)*

YES      SOMETIMES      NOT YET

3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?


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☐


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4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?


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☐
☐


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5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?

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☐
☐


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6. Does your baby walk beside furniture while holding on with only one hand?

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☐
☐


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**GROSS MOTOR TOTAL**


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## FINE MOTOR

YES      SOMETIMES      NOT YET

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


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☐
☐


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2. Does your baby *successfully* pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)


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☐
☐


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3. Does your baby pick up a small toy with the *tips* of his thumb and fingers? (You should see a space between the toy and his palm.)


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4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)


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5. Does your baby pick up a crumb or Cheerio with the *tips* of his thumb and a finger? He may rest his arm or hand on the table while doing it.


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☐
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6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?

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**FINE MOTOR TOTAL**


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\*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

## PROBLEM SOLVING

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



YES

☐

SOMETIMES

☐

NOT YET

☐

2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?

☐☐☐

3. When holding a toy in his hand, does your baby bang it against another toy on the table?

☐☐☐

4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?

☐☐☐

5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?

☐☐☐

6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)

☐☐☐

PROBLEM SOLVING TOTAL

## PERSONAL-SOCIAL

1. While your baby is on her back, does she put her foot in her mouth?



YES

☐

SOMETIMES

☐

NOT YET

☐

2. Does your baby drink water, juice, or formula from a cup while you hold it?

☐☐☐

3. Does your baby feed himself a cracker or a cookie?

☐☐☐

4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)

☐☐☐

5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?

☐☐☐

6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?

☐☐☐

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



**OVERALL** (continued)

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





## 9 Month ASQ-3 Information Summary

9 months 0 days through  
9 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	13.97		<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	17.82		<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	31.32		<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	28.72		<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	18.91		<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						