ASQ-3™

8 Month Questionnaire

7 months 0 days through 8 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:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. If you call to your baby when you are out of sight, does she look in the direction of your voice?	○	○	○	___
2. When a loud noise occurs, does your baby turn to see where the sound came from?	○	○	○	___
3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___
4. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	___
5. Does your baby respond to the tone of your voice and stop his activity at least briefly when you say "no-no" to him?	○	○	○	___
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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.)* 	○	○	○	___
2. Does your baby roll from his back to his tummy, getting both arms out from under him?	○	○	○	___

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GROSS MOTOR *(continued)*

		YES	SOMETIMES	NOT YET	
3.	Does your baby get into a crawling position by getting up on her hands and knees? 	○	○	○	___
4.	If you hold both hands just to balance your baby, does he support his own weight while standing? 	○	○	○	___
5.	When sitting on the floor, does your baby sit up straight for several minutes *without* using her hands for support? 	○	○	○	___ *
6.	When you stand your baby next to furniture or the crib rail, does he hold on without leaning his chest against the furniture for support? 	○	○	○	___

GROSS MOTOR TOTAL ___

**If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."*

FINE MOTOR

		YES	SOMETIMES	NOT YET	
1.	Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? *(If she already picks up a small object, mark "yes" for this item.)* 	○	○	○	___
2.	Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it? 	○	○	○	___
3.	Does your baby *try* to pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion, even if she isn't able to pick it up? *(If she already picks up a crumb or Cheerio, mark "yes" for this item.)* 	○	○	○	___
4.	Does your baby pick up a small toy with only one hand? 	○	○	○	___

FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. Does your baby *successfully* pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion? *(If he already picks up a crumb or Cheerio, mark "yes" for this item.)* 	○	○	○	___
6. Does your baby pick up a small toy with the *tips* of her thumb and fingers? *(You should see a space between the toy and her palm.)* 	○	○	○	___ *

FINE MOTOR TOTAL ___

**If Fine Motor Item 6 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a toy and put it in his mouth? 	○	○	○	___
2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___
3. Does your baby play by banging a toy up and down on the floor or table? 	○	○	○	___
4. Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	___
5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	○	○	○	___
6. When holding a toy in his hand, does your baby bang it against another toy on the table? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When lying on her back, does your baby play by grabbing her foot? 	○	○	○	___
2. When in front of a large mirror, does your baby reach out to pat the mirror? 	○	○	○	___
3. Does your baby try to get a toy that is out of reach? *(He may roll, pivot on his tummy, or crawl to get it.)*	○	○	○	___
4. While your baby is on her back, does she put her foot in her mouth? 	○	○	○	___
5. Does your baby drink water, juice, or formula from a cup while you hold it?	○	○	○	___
6. Does your baby feed himself a cracker or a cookie?	○	○	○	___

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

OVERALL *(continued)*

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

Baby Pediatric Symptom Checklist (7-8 months)

Patient Name: _____ DOB/FDN: _____ Date: _____
Name of person answering this form: _____ Relation to patient: _____
Nombre de la persona llenando esta forma: _____ Relación al paciente: _____

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child./ Algunas veces todos los niños lloran, gruñen o se quejan, tienen problemas al dormir o tienen problemas cuando llegan a lugares nuevos. Comparado a la mayoría de los niños/as de esta edad, usted diría que su niño hace estas cosas igual, un poco más o mucho más que otros niños de su misma edad?	Not at all/ Igual (0)	Some-what/ Un poco mas (1)	Very Much/ Mucho mas (2)
1. *Does your child have a hard time being with new people?* | ¿Su niño/a tiene dificultad al estar con personas desconocidas?			
2. *Does your child have a hard time in new places?* | ¿Su niño/a tiene dificultad al estar en lugares nuevos?			
3. *Does your child have a hard time with change?* | ¿Su niño/a tiene dificultad con los cambios?			
4. *Does your child mind being held by other people?* | ¿A su niño/a le molesta que lo carguen otras personas?			
		Total	/3
5. *Does your child cry a lot?* | ¿Su niño/a llora mucho?			
6. *Does your child have a hard time calming down?*| ¿Su niño/a tiene dificultad para calmarse?			
7. *Is your child fussy or irritable?* | ¿Su niño/a se enoja fácilmente o se irrita?			
8. *Is it hard to comfort your child?* | ¿Su niño/a es di fícil de consolar?			
		Total	/3
9. *Is it hard to keep your child on a schedule or routine?* ¿Es difícil mantener a su niño/a en un horario o una rutina establecida?			
10. *Is it hard to put your child to sleep?* | ¿Es difícil poner a su niño/a a dormir?			
11. *Is it hard to get enough sleep because of your child?* | ¿Es difícil para usted dormir lo suficiente debido a su niño/a?			
12. *Does your child have trouble staying asleep?* | ¿Su niño/a tiene dificultad para mantenerse dormido?			
		Total	/3
Reviewed by:			

Childhood Lead Assessment Questionnaire **Cuestionario de evaluación infantil de riesgo por el Plomo**	**YES Si**	**NO No**	**Un-sure No se**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? ¿Su hijo (a) es elegible paea inscribirse en Medicaid, Head Start, All kids o WIC?			
2. Does this child have a sibling with a blood level of 10mcg/dl or higher? ¿Su hijo(a) tiene un hermano(a) con nivel de plomo en la sangre de 10mcg/dl o mas alto?			
3. Does this child live in regularly visit a home built before 1978? ¿Su hijo(a) vive o visita regularmente una casa que ya haya sido construida antes de 1978?			
4. In the past year has this child been exposed to repairs, repainting, or renovation of a home built before 1978? ¿Desde el año pasado, ha sido expuesto su hijo/a a reparaciones, pintura o remodelaciones dela casa construida antes de 1978?			
5. Is this child a refugee or an adoptee from any foreign country? ¿Su hijo(a) ha sido exilado o ha sido adoptado de algun pais extranjero?			
6. Has this child ever been to Mexico, Central or South America, Asian Countries, or any country where exposure to lead from certain items could have occurred (cosmetics, home remedies, folk medicines, or glazed pottery)? ¿Su hijo(a) ha hido a los siguientes paises: Mexico, America Central, o del sur, Asia, China o India, o cualquier pais donde pudo haber estado expuesto a objetos que contienen plomo? (por ejemplo, cosmeticos , remedios caseros, medicinas tradicionales o ceramica vidriada?			
7. Does this child live with someone who has a job or a hobby that may involve lead (jewelry making, building renovation or repair, bridge construction, pluming, furniture refinishing, leaded glass, lead shots, bullets or lead fishing sinkers?) ¿Vive su hijo(a) con alguna persona que tenga un trabajo o un pasatiempo que incluya plomo (joyas , renovación o construción de puentes, plomeria, recabados de muebles o un trabajo con baterias o radiadores de automoviles , soladores de plomo, vidrio de plomo, balas			
8. At any time has this Child lived near a factory where lead is used? ¿En algun momento su hijo(a) ha vivido cerca de una fabrica donde se use plomo?			
9. Does this child reside in a high-risk zip code? (High-risk zip codes- LAKE: 60040, MCHENRY: 60034, All Chicago zip codes) ¿Su hijo(a) vive en un codigo postal de alto riesgo? (Codigo de alto riesgo LAKE- 60040, MCHENRY- 60034, Todos los codigos postal de Chicago)			