Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System
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with assistance from LaWanda Potter, Robert Nickel, and Jane Farrell

• 4 Month • Questionnaire

Please fill out the following information.

Child's name: _____

Child's date of birth: _____

Who is filling out this questionnaire? _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

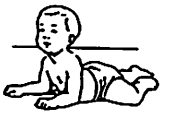
List people assisting in questionnaire completion: _____

_____

Today's date: _____

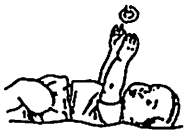
Administering program or provider: _____

ASQ

	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. Does your baby chuckle softly?	❑	❑	❑	___
2. After you have been out of sight, does your baby stop crying when he sees you?	❑	❑	❑	___
3. Does your baby stop crying when she hears a voice other than yours?	❑	❑	❑	___
4. Does your baby make high-pitched squeals?	❑	❑	❑	___
5. Does your baby laugh?	❑	❑	❑	___
6. Does your baby make sounds when looking at toys or people?	❑	❑	❑	___
		COMMUNICATION TOTAL		___
GROSS MOTOR *Be sure to try each activity with your child.*				
1. While on his back, does your baby move his head from side to side?	❑	❑	❑	___
2. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	❑	❑	❑	___
3. When he is on his tummy, does your baby hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds? 	❑	❑	❑	___
4. When she is on her tummy, does your baby hold her head straight up, looking around? (She can rest on her arms while doing this.) 	❑	❑	❑	___
5. When you hold him in a sitting position, does your baby hold his head steady?	❑	❑	❑	___
6. While on her back, does your baby bring her hands together over her chest, touching her fingers? 	❑	❑	❑	___
		GROSS MOTOR TOTAL		___
FINE MOTOR *Be sure to try each activity with your child.*				
1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? 	❑	❑	❑	___
2. When you put a toy in her hand, does your baby wave it about, at least briefly?	❑	❑	❑	___
3. Does your baby grab or scratch at his clothes?	❑	❑	❑	___

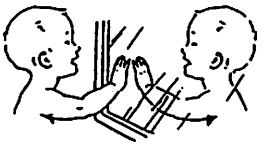
	YES	SOMETIMES	NOT YET	
FINE MOTOR *(continued)*				
4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?	❑	❑	❑	___
5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?	❑	❑	❑	___
6. When you hold her in a sitting position, does your baby reach for a toy on a table close by, even though her hand may not touch it?	❑	❑	❑	___
			FINE MOTOR TOTAL	___

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

1. When you move a toy slowly from side to side in front of his face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?	❑	❑	❑	___
2. When you move a small toy up and down slowly in front of her face (about 10 inches away), does your baby follow the toy with her eyes?	❑	❑	❑	___
3. When you hold him in a sitting position, does your baby look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?	❑	❑	❑	___
4. When you put a toy in her hand, does your baby look at it?	❑	❑	❑	___
5. When you put a toy in his hand, does your baby put the toy in his mouth?	❑	❑	❑	___
6. When you dangle a toy above her while she is lying on her back, does your baby wave her arms toward the toy? 	❑	❑	❑	___
			PROBLEM SOLVING TOTAL	___

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. Does your baby watch his hands? 	❑	❑	❑	___
2. When she has her hands together, does your baby play with her fingers?	❑	❑	❑	___
3. When he sees the breast or bottle, does your baby know he is about to be fed?	❑	❑	❑	___
4. Does your baby help hold the bottle with both hands at once or, when nursing, does she hold the breast with her free hand?	❑	❑	❑	___

	YES	SOMETIMES	NOT YET	
PERSONAL-SOCIAL *(continued)*				
5. Before you smile or talk to him, does your baby smile when he sees you nearby?	❑	❑	❑	___
6. When in front of a large mirror, does your baby smile or coo at herself? 	❑	❑	❑	___
			PERSONAL-SOCIAL TOTAL	___

OVERALL *Parents and providers may use the space below or 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 any family history of childhood deafness or hearing impairment? YES ❑ NO ❑
   If yes, explain: _____
5. Has your child had any medical problems in the last several months? YES ❑ NO ❑
   If yes, explain: _____
6. Does anything about your child worry you? YES ❑ NO ❑
   If yes, explain: _____

4 Month ASQ Information Summary

Child's name: _____ Date of birth: _____

Who is filling out the ASQ? _____ Relationship to child: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ completion: _____

Today's date: _____ _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any parents' 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. Recent medical problems? YES NO
   Comments:
6. Other concerns? YES NO
   Comments:

SCORING THE QUESTIONNAIRE

1. Be sure each question has been answered. If a question 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.

Total	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	○	○	○	○	○	○	○	○	○	○	○	○	○
Gross motor	○	○	○	○	○	○	○	○	○	○	○	○	○
Fine motor	○	○	○	○	○	○	○	○	○	○	○	○	○
Problem solving	○	○	○	○	○	○	○	○	○	○	○	○	○
Personal-social	○	○	○	○	○	○	○	○	○	○	○	○	○
Total	0	5	10	15	20	25	30	35	40	45	50	55	60

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.

4 months

	Score	Cutoff
Communication		33.3
Gross motor		40.1
Fine motor		27.5
Problem solving		35.0
Personal-social		33.0

	Communication	Gross motor	Fine motor	Problem solving	Personal-social
1	○○○	○○○	○○○	○○○	○○○
2	○○○	○○○	○○○	○○○	○○○
3	○○○	○○○	○○○	○○○	○○○
4	○○○	○○○	○○○	○○○	○○○
5	○○○	○○○	○○○	○○○	○○○
6	○○○	○○○	○○○	○○○	○○○
	Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes No
2.	Does your child take an interest in other children?	Yes No
3.	Does your child like climbing on things, such as up stairs?	Yes No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes No
5.	Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes No
8.	Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?	Yes No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes No
10.	Does your child look you in the eye for more than a second or two?	Yes No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes No
12.	Does your child smile in response to your face or your smile?	Yes No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes No
14.	Does your child respond to his/her name when you call?	Yes No
15.	If you point at a toy across the room, does your child look at it?	Yes No
16.	Does your child walk?	Yes No
17.	Does your child look at things you are looking at?	Yes No
18.	Does your child make unusual finger movements near his/her face?	Yes No
19.	Does your child try to attract your attention to his/her own activity?	Yes No
20.	Have you ever wondered if your child is deaf?	Yes No
21.	Does your child understand what people say?	Yes No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes No

The Childhood Autism Spectrum Test (CAST)

Child's Name: ..... Age: ..... Sex: Male / Female

Birth Order: ..... Twin or Single Birth: .....

Parent/Guardian: .....

Parent(s) occupation: .....

Age parent(s) left full-time education: .....

Address: .....
.....
.....

Tel.No: ..... School: .....

Please read the following questions carefully, and circle the appropriate answer. All responses are confidential.

1. Does s/he join in playing games with other children easily?	Yes	No
2. Does s/he come up to you spontaneously for a chat?	Yes	No
3. Was s/he speaking by 2 years old?	Yes	No
4. Does s/he enjoy sports?	Yes	No
5. Is it important to him/her to fit in with the peer group?	Yes	No
6. Does s/he appear to notice unusual details that others miss?	Yes	No
7. Does s/he tend to take things literally?	Yes	No
8. When s/he was 3 years old, did s/he spend a lot of time pretending (e.g., play-acting being a superhero, or holding teddy's tea parties)?	Yes	No
9. Does s/he like to do things over and over again, in the same way all the time?	Yes	No
10. Does s/he find it easy to interact with other children?	Yes	No
11. Can s/he keep a two-way conversation going?	Yes	No

12. Can s/he read appropriately for his/her age?	Yes	No
13. Does s/he mostly have the same interests as his/her peers?	Yes	No
14. Does s/he have an interest which takes up so much time that s/he does little else?	Yes	No
15. Does s/he have friends, rather than just acquaintances?	Yes	No
16. Does s/he often bring you things s/he is interested in to show you?	Yes	No
17. Does s/he enjoy joking around?	Yes	No
18. Does s/he have difficulty understanding the rules for polite behaviour?	Yes	No
19. Does s/he appear to have an unusual memory for details?	Yes	No
20. Is his/her voice unusual (e.g., overly adult, flat, or very monotonous)?	Yes	No
21. Are people important to him/her?	Yes	No
22. Can s/he dress him/herself?	Yes	No
23. Is s/he good at turn-taking in conversation?	Yes	No
24. Does s/he play imaginatively with other children, and engage in role-play?	Yes	No
25. Does s/he often do or say things that are tactless or socially inappropriate?	Yes	No
26. Can s/he count to 50 without leaving out any numbers?	Yes	No
27. Does s/he make normal eye-contact?	Yes	No
28. Does s/he have any unusual and repetitive movements?	Yes	No
29. Is his/her social behaviour very one-sided and always on his/her own terms?	Yes	No
30. Does s/he sometimes say "you" or "s/he" when s/he means "I"?	Yes	No

31. Does s/he prefer imaginative activities such as play-acting or story-telling, rather than numbers or lists of facts? Yes No

32. Does s/he sometimes lose the listener because of not explaining what s/he is talking about? Yes No

33. Can s/he ride a bicycle (even if with stabilisers)? Yes No

34. Does s/he try to impose routines on him/herself, or on others, in such a way that it causes problems? Yes No

35. Does s/he care how s/he is perceived by the rest of the group? Yes No

36. Does s/he often turn conversations to his/her favourite subject rather than following what the other person wants to talk about? Yes No

37. Does s/he have odd or unusual phrases? Yes No

SPECIAL NEEDS SECTION
Please complete as appropriate

38. Have teachers/health visitors ever expressed any concerns about his/her development? Yes No

If Yes, please specify.....

39. Has s/he ever been diagnosed with any of the following?:

Language delay Yes No

Hyperactivity/Attention Deficit Disorder (ADHD) Yes No

Hearing or visual difficulties Yes No

Autism Spectrum Condition, incl. Asperger's Syndrome Yes No

A physical disability Yes No

Other (please specify) Yes No