ASQ-3 Ages & Stages Questionnaires®

3 months 0 days through 4 months 30 days

4 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, # of weeks premature: _____

Baby's gender:
◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

Relationship to baby:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

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 #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

P101040100

4 Month Questionnaire

3 months 0 days through 4 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:

_____

_____

_____

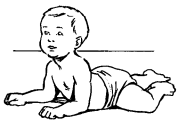
_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby chuckle softly?	◯	◯	◯	___
2. After you have been out of sight, does your baby smile or get excited 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

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he 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 your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds? 	◯	◯	◯	___
4. When your baby is on her tummy, does she hold her head straight up, looking around? *(She can rest on her arms while doing this.)* 	◯	◯	◯	___

E101040200

GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. When you hold him in a sitting position, does your baby hold his head steady?	◯	◯	◯	___
6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers? 	◯	◯	◯	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
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?	◯	◯	◯	___
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 your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it?	◯	◯	◯	___

FINE MOTOR TOTAL ___

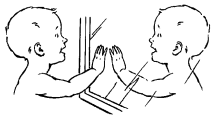
PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When you move a toy slowly from side to side in front of your baby's 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 your baby's face (about 10 inches away), does your baby follow the toy with her eyes?	◯	◯	◯	___
3. When you hold your baby in a sitting position, does he 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?	◯	◯	◯	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. When you dangle a toy above your baby while she is lying on her back, does your baby wave her arms toward the toy? 	◯	◯	◯	___
		PROBLEM SOLVING TOTAL		___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby watch his hands? 	◯	◯	◯	___
2. When your baby has her hands together, does she play with her fingers?	◯	◯	◯	___
3. When your baby sees the breast or bottle, does he seem to 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?	◯	◯	◯	___
5. Before you smile or talk to your baby, does he 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 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

4 Month ASQ-3 Information Summary

3 months 0 days through 4 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	34.60		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	38.41		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	29.62		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	34.98		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	33.16		●	●	●	●	●	●	●	○	○	○	○	○	○

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? 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: 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						

P101040600

TEHDI
Texas Early Hearing Detection and Intervention

HEARING CHECKLIST FOR PARENTS

STAGES OF HEARING, LANGUAGE, AND SPEECH DEVELOPMENT FROM BIRTH TO 5 YEARS CHECKLIST

Please use this checklist! Look at your checklist often. Find your child's age level. Check Yes or No for every item. If your child does not pass any two items within an age level, call your doctor to make an appointment.

Age Level	Hearing and Understanding	Check One	Speech	Check One
Birth to 3 months	• Gives a startle response to loud, sudden noises within 3 feet. • Calms to a familiar, friendly voice. • Wakes up when you speak or make noise nearby.	Yes ☐ No ☐	• Coos and gurgles. • Laughs and uses voice when playing. • Watches your face when spoken to.	Yes ☐ No ☐
3 to 6 months	• Looks to see where sounds come from. • Becomes frightened by an angry voice. • Smiles when spoken to. • Likes to play with toys or objects that make noise.	Yes ☐ No ☐	• Babbles (uses a series of sounds). • Makes at least 4 different sounds when using his or her voice. • Babbles to people when they speak.	Yes ☐ No ☐
6 to 9 months	• Turns and looks to you when you are speaking in a quiet voice. • Waves when you say "bye-bye." • Stops for a moment when you say "no-no." • Looks at objects or pictures when someone talks about them.	Yes ☐ No ☐	• Babbles using "song-like tunes." • Uses voice to get your attention instead of crying. • Uses different sounds and appears to be naming things.	Yes ☐ No ☐
9 to 12 months	• Points to or looks at familiar objects or people when asked to. • Looks sad when scolded. • Follows directions ("Open your mouth," "Give me the ball"). • "Dances" and makes sounds to music.	Yes ☐ No ☐	• Uses jargon (appears to be talking). • Uses consonant sounds like b, d, g, m, and n when talking. • Jabbers in response to a human voice, changes loudness of voice, and uses rhythm and tone.	Yes ☐ No ☐
NOTE: Be aware that babies between 12 to 15 months old say their first true words.				
12 to 18 months	• Points to body parts (hair, eyes, nose, mouth) when asked to. • Brings objects to you when asked. • Hears and identifies sounds coming from another room or from outside.	Yes ☐ No ☐	• Gives one-word answers to questions. • Imitates many new words. • Uses words of more than one syllable with meaning ("bottle"). • Speaks 10 to 20 words.	Yes ☐ No ☐
18 to 24 months	• Understands simple "yes/no" questions. • Understands simple phrases with prepositions ("in the cup"). • Enjoys being read to and points to pictures when asked.	Yes ☐ No ☐	• Uses his or her own first name. • Uses "my" to get toys and other objects. • Tells experiences using jargon and words. • Uses 2-word sentences like "my shoes," "go bye-bye," "more juice."	Yes ☐ No ☐

Flip chart over to see the checklist for 24 months to 5 years of age. ►

HEARING CHECKLIST FOR PARENTS

(continued from the other side)

Age Level	Hearing and Understanding	Check One	Speech	Check One
24 to 30 months	• Understands negative statements ("no more," "not now"). • Selects objects according to size (big, little). • Follows simple directions ("Get your shoes and socks").	Yes ☐ No ☐	• Answers questions ("What do you do when you are sleepy?"). • Uses plural words (2 books, dogs). • Speaks 100 to 200 words.	Yes ☐ No ☐
30 to 36 months	• Understands uses of objects ("Show me what goes on your foot"). • Understands the concept of one and can hand you one of something (1 ball, 1 cookie). • Correctly identifies boys and girls. • Understands many action words like "run" or "jump."	Yes ☐ No ☐	• Uses question forms correctly (who? what? where? when?). • Uses negative forms ("It is not," "I can't"). • Relates experiences using 4- to 5-word sentences.	Yes ☐ No ☐
3 to 4 years	• Understands "why" questions ("Why do you wash your hands?"). • Understands opposites like "fast" or "slow." • Correctly selects objects according to color.	Yes ☐ No ☐	• Uses different forms of action words ("I play," "I want to play," "We played"). • Counts to 10. • Tells you about pictures in books or about a drawing ("I made a purple flower").	Yes ☐ No ☐
4 to 5 years	• Understands size comparisons (big, bigger, biggest). • Understands many pronouns ("Give it to her," "Give it to him"). • Follows a 2- to 3-step command ("Go to the kitchen, get a cup, put it on the table").	Yes ☐ No ☐	• Speaks at least 1,500 words. • Says most sounds correctly except possibly "s" and "th." • Talks freely to family and friends using full sentences that most people can understand.	Yes ☐ No ☐

Do you hear me?

This may be the most important question you ever answer for your baby.

- Babies learn to talk during their first years. Words help them share thoughts and feelings with the important people in their world.
- As your baby hears words, language and learning begin and speech develops.
- The checklist above and on the other side shows you how learning helps the speech development of your child.
- Watch your child grow through stages of normal hearing and speech development. Seek help immediately if your child is not developing according to the checklist.

What can you do?

- Some infants are born with normal hearing and later become deaf or hard of hearing. That is why you must continue to fill out the checklist.
- If you think your child has a hearing problem, ***do not delay***. Seek help ***immediately***.

NOW...

1. You know your child best. If you suspect a possible hearing loss, talk to your doctor about getting a hearing test.
2. For questions or more information, contact Texas Early Hearing Detection and Intervention (TEHDI).
   Phone: **1-800-252-8023, ext. 7726** toll free
   (Use relay option of your choice to call if needed.)
   Email: **tehdi@dshs.texas.gov**
   Website: **www.dshs.texas.gov/tehdi**

Source: Maryland Department of Health and Mental Hygiene. "Baby Do Your Hear Me?" (Factsheet)

#1-323_8/17

TEXAS Health and Human Services | Texas Department of State Health Services

TEXAS Health and Human Services
Texas Department of State Health Services

Lead Risk Questionnaire

Form Pb-110

Purpose: To identify children who need to be tested for lead exposure.

Instructions

- If **Yes or Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

Patient's Name: _____ **DOB:**_____ **Medicaid #:** _____

Provider's Name: _____ **Administered by:**_____ **Date** _____

Questions	Yes or Don't Know	No
1. Does your child live in or visit a home, day-care or other building built before 1978?	☐	☐
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?	☐	☐
3. Does your child eat or chew on non-food things like paint chips or dirt?	☐	☐
4. Does your child have a family member or friend who has or did have an elevated blood lead level?	☐	☐
5. Is your child a newly arrived refugee or foreign adoptee?	☐	☐
6. Does your child come in contact with an adult whose job or hobby involves lead exposure?	☐	☐
7. Does your family use products from other countries such as pottery, health remedies, spices, or food?	☐	☐

Examples (Question 6)

- House construction or repair
- Battery manufacturing or repair
- Burning lead-painted wood
- Automotive repair shop or junk yard
- Going to a firing range or reloading bullets
- Chemical preparation
- Valve and pipe fittings
- Brass/copper foundry
- Refinishing furniture
- Making fishing weights
- Radiator repair
- Pottery making
- Lead smelting
- Welding

Examples (Question 7)

- Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda
- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.
- Foods canned or packaged outside the U.S.

Test Immediately

Texas Department of State Health Services

Tuberculosis (TB) Questionnaire for Children

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) or a TB blood test (called an IGRA) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box	**Yes**	**No**	**Don't Know**
TB can cause a fever of long duration, unexplained weight loss, a cough (lasting over two weeks), or coughing up blood. **As far as you know has your child:** • been around anyone with any of these symptoms or problems? or • had any of these symptoms or problems? or • been around anyone sick with TB?			
Was your child born in: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries:			
To your knowledge, has your child spent time (longer than 3 weeks) with: anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? ☐ Yes (specify date ____/____/_____) ☐ No
Has your child ever had a positive TB skin test? ☐ Yes (specify date ____/____/_____) ☐ No
Has your child ever had a positive TB blood test? ☐ Yes (specify date ____/____/_____) ☐ No

For school/healthcare provider use only
****

PPD / IGRA administered (circle one)

Date Administered: _____/_____/_____ Date Read (if PPD): _____/_____/_____

Result of PPD: _____ mm Result of IGRA test: ☐ Positive ☐ Negative ☐ Indeterminate/Invalid

Type of service provider (i.e. school, Health Steps, other clinics): _____

PPD/IGRA provider: _____ _____
signature printed name

Provider phone number: _____

City _____ County _____

If positive, referral to healthcare provider: ☐ Yes ☐ No

If yes, name/contact of provider: _____