ASQ3 Ages & Stages Questionnaires® 1 month 0 days through 2 months 30 days Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed:								
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2 Month Questionnaire

1 month 0 days through 2 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:	Notes:				
☑ Try each activity with your baby before marking a re	sponse.				
✓ Make completing this questionnaire a game that is you and your baby.	fun for				
☑ Make sure your baby is rested and fed.					
✓ Please return this questionnaire by	·				
COMMUNICATION		YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling so	ounds?	\bigcirc	\bigcirc	\bigcirc	
2. Does your baby make cooing sounds such as "ooo," "g	gah," and "aah"?	\bigcirc	\bigcirc	\bigcirc	
3. When you speak to your baby, does she make sounds k	oack to you?	\bigcirc	\bigcirc	\bigcirc	
1. Does your baby smile when you talk to him?		\bigcirc	\bigcirc	\bigcirc	
5. Does your baby chuckle softly?		\bigcirc	\bigcirc	\bigcirc	
5. After you have been out of sight, does your baby smile when she sees you?	e or get excited	\bigcirc	\bigcirc	\bigcirc	
		(COMMUNICATIO	ON TOTAL	
GROSS MOTOR		YES	SOMETIMES	NOT YET	
While your baby is on his back, does he wave his arms and squirm?	and legs, wiggle,	\bigcirc	\bigcirc	\bigcirc	
2. When your baby is on her tummy, does she turn her he	ead to the side?	\bigcirc	\bigcirc	\bigcirc	
3. When your baby is on his tummy, does he hold his head a few seconds?	d up longer than	\bigcirc	\bigcirc	\bigcirc	
1. When your baby is on her back, does she kick her legs?	?	\bigcirc	\bigcirc	\bigcirc	
5. While your baby is on his back, does he move his head f	rom side to side?	\bigcirc	\bigcirc	\bigcirc	
 After holding her head up while on her tummy, does yo head back down on the floor, rather than let it drop or 		\bigcirc	\bigcirc	\bigcirc	
			GROSS MOTO	OR TOTAL	

FI	NE MOTOR	YES	SOMETIMES	NOT YET	
1.	Is your baby's hand usually tightly closed when he is awake? (If your baby used to do this but no longer does, mark "yes.")	\bigcirc	\bigcirc		
2.	Does your baby grasp your finger if you touch the palm of her hand?	_	0	\bigcirc	
3.	When you put a toy in his hand, does your baby hold it in his hand briefly?	0		0	_
4.	Does your baby touch her face with her hands?	\bigcirc	\bigcirc	\bigcirc	
5.	Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)?	\circ	0		*
6.	Does your baby grab or scratch at her clothes?	\bigcirc	\bigcirc	\bigcirc	
		*]:	FINE MOT f Fine Motor item 5 is r mark Fine Motor ite	marked "yes,"	_
Ρŀ	ROBLEM SOLVING	YES	SOMETIMES	NOT YET	
1.	Does your baby look at objects that are 8–10 inches away?	\bigcirc	\bigcirc	\bigcirc	
2.	When you move around, does your baby follow you with his eyes?	\bigcirc		\bigcirc	
3.	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 her eyes, sometimes turning her head?	\circ	\bigcirc		
4.	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 his eyes?	\bigcirc	\bigcirc	\bigcirc	
5.	When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?	0	0	\circ	
6.	When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy?	\circ	\bigcirc	\bigcirc	_
			PROBLEM SOLVI	NG TOTAL	

	ASQ3		2 Month Que	stionnaire	page 4 of 5
P	ERSONAL-SOCIAL	YES	SOMETIMES	NOT YET	
1.	Does your baby sometimes try to suck, even when she's not feeding?	\bigcirc	\bigcirc	\bigcirc	
2.	Does your baby cry when he is hungry, wet, tired, or wants to be held?	\bigcirc	\bigcirc	\bigcirc	
3.	Does your baby smile at you?	\bigcirc	\bigcirc	\bigcirc	
4.	When you smile at your baby, does she smile back?	\bigcirc	\bigcirc	\bigcirc	
5.	Does your baby watch his hands?	\bigcirc	\bigcirc	\bigcirc	
6.	When your baby sees the breast or bottle, does she seem to know she is about to be fed?	\bigcirc	\bigcirc		
		Р	ersonal-soci	AL TOTAL	
0	VERALL				
Ра	rents and providers may use the space below for additional comments.				
1.	Did your baby pass the newborn hearing screening test? If no, explain:		YES	○ NC)
2.	Does your baby move both hands and both legs equally well? If no, explain:		YES	O NO)
3.	Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain:		YES	O NC)

OVERALL (co	ontinued)			
4. Has your baby ha	d any medical problems? If yes, explain:	YES	O NO	
5. Do you have consleeping)? If yes,	cerns about your baby's behavior (for example, eating, explain:	YES	O NO	
				/
6. Does anything ab	oout your baby worry you? If yes, explain:	YES	O NO	