4 Month ASQ-3 Information Summary

Baby's name: williams, brandon
Baby ID: 5038829
Program: Help Me Grow Central Intake
Caregiver's Name: Scott, Dominique
Caregiver's Email: dominique0727@yahoo.com

Date ASQ completed: 2023-05-21
Date of birth: 2023-01-05
Person who completed ASQ-3: Scott, Dominique
Provider: Unassigned
Caregiver's Phone: 4409916910

1. **SCORING RESULTS:**

Area	Cutoff	Total Score
Communication	34.60	**60.00**
Gross Motor	38.41	**60.00**
Fine Motor	29.62	**60.00**
Problem Solving	34.98	**60.00**
Personal-Social	33.16	**45.00**

2. **OVERALL RESPONSES:** Boldface uppercase responses require follow-up. See *ASQ-3 User's Guide* for guidance.

1. Does your baby use both hands and both legs equally well? If no, explain:
   Yes
   Comments:
2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:
   Yes
   Comments:
3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:
   No
   Comments:
4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:
   No
   Comments:
5. Do you have concerns about your baby's vision? If yes, explain:
   No
   Comments:
6. Has your baby had any medical problems in the last several months? If yes, explain:
   YES
   Comments: operation
7. Do you have any concerns about your baby's behavior? If yes, explain:
   No
   Comments:
8. Does anything about your baby worry you? If yes, explain:
   No
   Comments:

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total 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, 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. **INDIVIDUAL ITEM RESPONSES:** (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing)

	1	2	3	4	5	6
Communication	Y	Y	Y	Y	Y	Y
Gross Motor	Y	Y	Y	Y	Y	Y
Fine Motor	Y	Y	Y	Y	Y	Y
Problem Solving	Y	Y	Y	Y	Y	Y
Personal-Social	S	N	Y	Y	Y	Y

Help Me Grow Central Intake
6393 Oak Tree Blvd Ste 102

Independence, Ohio 44131
216-236-0813
mbixel@brightbeginningskids.org

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: May 21, 2023

Baby's information

Baby's first name: brandon
Middle initial:
Baby's last name: williams

Baby's date of birth: Jan 5, 2023
If baby was born 3 or more weeks prematurely, # of weeks premature: 0
Baby's gender: (●) Male ( ) Female

Person filling out questionnaire

First name: Dominique
Middle initial:
Last name: Scott

Street address: 45 S.Richardson ave
Relationship to baby: (●) Parent ( ) Guardian ( ) Teacher ( ) Child care provider ( ) Grandparent or other relative ( ) Foster parent ( ) Other:

City: columbus
State/Province: Ohio
ZIP/Postal code: 43204

Country: United States
Home telephone number: 4409916910
Other telephone number:

E-mail address: dominique0727@yahoo.com

Names of people assisting in questionnaire completion:

Program Information

Baby ID #: 5038829
Age at administration in months and days: 4 months 16 days

Program ID #: 24247
If premature, adjusted age in months and days:

Program name: Help Me Grow Central Intake

P101040100

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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?	●	○	○	10
2. After you have been out of sight, does your baby smile or get excited when he sees you?	●	○	○	10
3. Does your baby stop crying when she hears a voice other than yours?	●	○	○	10
4. Does your baby make high-pitched squeals?	●	○	○	10
5. Does your baby laugh?	●	○	○	10
6. Does your baby make sounds when looking at toys or people?	●	○	○	10

COMMUNICATION TOTAL 60.0

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he move his head from side to side?	●	○	○	10
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?	●	○	○	10
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?	●	○	○	10
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.)*	●	○	○	10

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GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. When you hold him in a sitting position, does your baby hold his head steady?	●	○	○	10
6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers?	●	○	○	10
			GROSS MOTOR TOTAL	60.0

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)?	●	○	○	10
2. When you put a toy in her hand, does your baby wave it about, at least briefly?	●	○	○	10
3. Does your baby grab or scratch at his clothes?	●	○	○	10
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?	●	○	○	10
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?	●	○	○	10
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?	●	○	○	10
			FINE MOTOR TOTAL	60.0

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?	●	○	○	10
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?	●	○	○	10
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?	●	○	○	10
4. When you put a toy in her hand, does your baby look at it?	●	○	○	10
5. When you put a toy in his hand, does your baby put the toy in his mouth?	●	○	○	10

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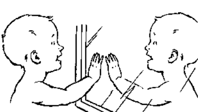
PROBLEM SOLVING *(continued)*

	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?	●	○	○	10
			PROBLEM SOLVING TOTAL	60.0

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby watch his hands?	○	●	○	5
2. When your baby has her hands together, does she play with her fingers?	○	○	●	0
3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?	●	○	○	10
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?	●	○	○	10
5. Before you smile or talk to your baby, does he smile when he sees you nearby?	●	○	○	10
6. When in front of a large mirror, does your baby smile or coo at herself?	●	○	○	10
			PERSONAL-SOCIAL TOTAL	45.0



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

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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

operation

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

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