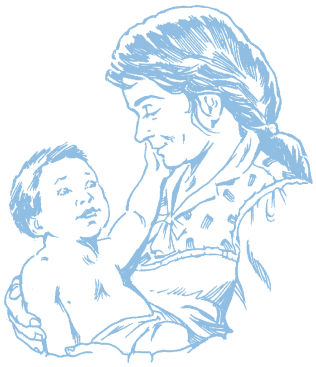
Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By **Diane Bricker** and **Jane Squires**
with assistance from ***Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly,*** *and* ***Jane Farrell***

8 Month Questionnaire



On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Be sure to try each activity with your child before checking a box.
- ☑ Try to make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested, fed, and ready to play.
- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Look forward to filling out another questionnaire in _____ months.

ASQ™

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8 Month Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

_____

Today's date: _____

Person 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: _____

_____

Administering program or provider: _____

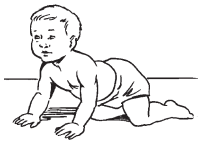
ASQ™

	YES	SOMETIMES	NOT YET	

COMMUNICATION *Be sure to try each activity with your child.*

1. If you call to your baby when you are out of sight, does he 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 her activity at least briefly when you say "no-no" to her?	❑	❑	❑	____
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (He may say these sounds without referring to any particular object or person.)	❑	❑	❑	____
		COMMUNICATION TOTAL		____

GROSS MOTOR *Be sure to try each activity with your child.*

1. When you put her on the floor, does your baby lean on her hands while sitting? (If she already sits up straight without leaning on her hands, check "yes" for this item.) 	❑	❑	❑	____
2. Does your baby roll from his back to his tummy, getting both arms out from under him?	❑	❑	❑	____
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 him, does your baby 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 him next to furniture or the crib rail, does your baby 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 as "yes."*

	YES	SOMETIMES	NOT YET	

FINE MOTOR *Be sure to try each activity with your child.*

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, check "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?

❑ ❑ ❑ ____

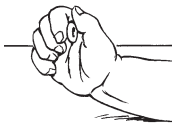
3. Does your baby *try* to pick up a crumb or Cheerio by using her thumb and all her fingers in a raking motion, even if she isn't able to pick it up? (If she already picks up a crumb or Cheerio, check "yes" for this item.)

❑ ❑ ❑ ____

4. Does your baby pick up small toys with only one hand?

❑ ❑ ❑ ____

5. Does your baby *successfully* pick up a crumb or Cheerio by using his thumb and all his fingers in a raking motion? (If he already picks up a crumb or Cheerio, check "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 as "yes."*

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

1. Does your baby pick up a toy and put it in his mouth?

❑ ❑ ❑ ____

2. When she is on her back, does your baby 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?

❑ ❑ ❑ ____

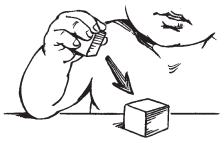
	YES	SOMETIMES	NOT YET	

PROBLEM SOLVING *(continued)*

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?



❑ ❑ ❑ ____

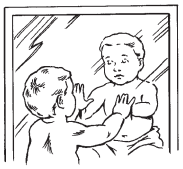
PROBLEM SOLVING TOTAL ____

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

1. While 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 on her back, does your baby 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 bottom of the next 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 her feet flat on the surface most of the time? YES ❑ NO ❑

   If no, explain: _____

OVERALL *(continued)*

4. Does either parent have a family history of childhood deafness or hearing impairment? YES ❑ NO ❑

   If yes, explain: _____

5. Do you have concerns about your child's vision? YES ❑ NO ❑

   If yes, explain: _____

6. Has your child had any medical problems in the last several months? YES ❑ NO ❑

   If yes, explain: _____

7. Does anything about your child worry you? YES ❑ NO ❑

   If yes, explain: _____