2 Month Well Child Check

Name: ______________________________ **Date: _________________**

Diet:

Method of feeding baby? _______________________

If breast feeding, do you supplement with a Vitamin D supplement? _______________

Frequency of feeding? _______________________

Amount/duration of feeding? _______________________

Nighttime awakenings? _______________________

Does baby use pacifier? _______________________

Elimination:

How many wet diapers a day? _______________________

How many stool diapers a day? _______________________

Sleep:

Is baby put on back to sleep? _______________________

Does baby sleep in own crib? _______________________

Are you avoiding loose, soft bedding? _______________________

Does baby do tummy time? _______________________

Behavior/Temperament

Fussy times are normal.

How do you calm the baby? ____

Development:

Do you have any concerns about your child's development, behavior, or learning? yes no

If yes, please describe: ____

Babies at 2 month almost always will (please circle yes or no)

-	smile spontaneously and responsively	yes no
-	regards face	yes no
-	follow to midline and past	yes no
-	vocalizes and say ooh and ahh	yes no
-	Child fixes/follows past midline	yes no
-	move arms and legs symmetrically	yes no
-	lift head and hold at 45 degrees	yes no

Some babies can

-	regard their own hand	yes no
-	start to sequel or laugh	yes no
-	able to hold up head when prone	yes no
-	starting to push up with arms with head to 90 degrees	yes no
-	consistent head control in supported sitting position	yes no
-	bear weight on legs	yes no

Social:

How is your home situation? ____

What are your plans for daycare? ____

What are you the parents work situation? ____

Ages & Stages Questionnaires®

1 month 0 days through 2 months 30 days

2 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: ____________________

P101020100

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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:

- ☑ 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 sometimes make throaty or gurgling sounds?	○	○	○	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	○	○	○	___
3. When you speak to your baby, does she make sounds back to you?	○	○	○	___
4. Does your baby smile when you talk to him?	○	○	○	___
5. Does your baby chuckle softly?	○	○	○	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	○	○	○	___
2. When your baby is on her tummy, does she turn her head to the side?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	○	○	○	___
4. When your baby is on her back, does she kick her legs?	○	○	○	___
5. While your baby is on his back, does he move his head from side to side?	○	○	○	___
6. 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?	○	○	○	___

GROSS MOTOR TOTAL ___

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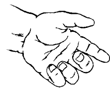
FINE MOTOR

	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."*)	○	○	○	___
2. Does your baby grasp your finger if you touch the palm of her hand?	○	○	○	___
3. When you put a toy in his hand, does your baby hold it in his hand briefly?	○	○	○	___
4. Does your baby touch her face with her hands?	○	○	○	___
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)? 	○	○	○	___ *
6. Does your baby grab or scratch at her clothes?	○	○	○	___

FINE MOTOR TOTAL ___

**If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby look at objects that are 8–10 inches away?	○	○	○	___
2. When you move around, does your baby follow you with his eyes?	○	○	○	___
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?	○	○	○	___
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?	○	○	○	___
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?	○	○	○	___
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy?	○	○	○	___

PROBLEM SOLVING TOTAL ___

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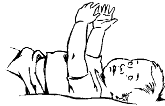
PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	○	○	○	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	○	○	○	___
3. Does your baby smile at you?	○	○	○	___
4. When you smile at your baby, does she smile back?	○	○	○	___
5. Does your baby watch his hands? 	○	○	○	___
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Did your baby pass the newborn hearing screening test? If no, explain: ○ YES ○ NO

2. Does your baby move both hands and both legs equally well? If no, explain: ○ YES ○ NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: ○ YES ○ NO

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OVERALL *(continued)*

4. Has your baby had any medical problems? If yes, explain: ◯ YES ◯ NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain: ◯ YES ◯ NO

6. Does anything about your baby worry you? If yes, explain: ◯ YES ◯ NO

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2 Month ASQ-3 Information Summary

1 months 0 days through 2 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	22.77		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Gross Motor	41.84		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Fine Motor	30.16		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Problem Solving	24.62		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Personal-Social	33.71		◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Passed newborn hearing screening test? Yes **NO**
   Comments:

2. Moves both hands and both legs equally well? Yes **NO**
   Comments:

3. Family history of hearing impairment? **YES** No
   Comments:

4. Any medical problems? **YES** No
   Comments:

5. Concerns about behavior? **YES** No
   Comments:

6. 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						

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Risk Indicators for Hearing Loss Checklist

(*To be used with the* ***Developmental Scales*** *form when performing KBH screens for birth through four years of age.*)

Child's name: ____ Birthdate: _______________

What was your child's birth weight? ________ Premature? _________ By how many weeks? _______

Was the child's hearing screened as a newborn? Yes ____ No ____ Unknown ____

Results of the testing/screening: ____

Has your child's hearing been tested or screened since birth? Yes ____ No ____ Unknown ____

Results of the testing/screening: ____

Directions: Mark an X in the appropriate column. *If an indicator exists but has been referred in a previous screening, note to whom the child was referred and note the follow-up recommendations.*

{**N** = indicator for infants birth through 28 days old who *did not* have newborn hearing screening; for children older than 28 days, answer all questions.}

YES NO

____ ____ 1. Do you have a concern about your child's hearing, speech, language or other development delay?

List concerns:____

____ ____ 2. **N** As a newborn, did your child have an illness/condition requiring 48 hours or more in the NICU?

Explain: ____

____ ____ 3. **N** Was your child exposed to any of the following during the mother's pregnancy? Check all that apply:

toxoplasmosis ☐ syphilis ☐ rubella ☐ cytomegalovirus ☐ herpes ☐ unknown ☐

____ ____ 4. **N** Does your child have any abnormal features of the outer ear, ear canal, mouth, nose, neck or head?

Explain: ____

____ ____ 5. **N** Have any of your child's relatives had a permanent hearing loss before the age of 5?

Explain: ____

____ ____ 6. **N** Was your child diagnosed at birth as having a syndrome or condition known to include a sensorineural or conductive hearing loss or eustachian tube dysfunction?

Explain: ____

____ ____ 7. Has your child been diagnosed as having any syndromes associated with progressive hearing loss such as Down, Usher, Waardenburg; a neurodegenerative disorder such as Hunter syndrome; or sensory motor neuropathies such as Friedreich's ataxia or Charcot-Maire-Tooth Syndrome?

Explain: ____

____ ____ 8. Has your child had bacterial meningitis (or other postnatal infections) associated with hearing loss? If yes, at what age? _________________ Hearing testing since then? ______________________

____ ____ 9. Has child ever had any head trauma?

Explain: ____

____ ____ 10. As a newborn, did your child need an exchange transfusion because of hyperbilirubinemia, or have the need for mechanical ventilation, or conditions requiring ECMO?

Explain: ____

____ ____ 11. Has your child had otitis media with effusion that lasts for more than 3 months? Yes ___ No ___

If yes, were tubes placed? Yes ___ No ___ If yes, when? ___________ Are they in place now? Yes ___ No ___

Note: The presence of any risk indicator denotes need for screening every six months up to three years of age or as otherwise indicated by an audiologist.

Pass = All "NO" responses. Refer = One or more "YES" response(s). **Check One: Pass** ☐ **Refer** ☐
If other, explain: ____

Screener: ____ **Date**: _________________

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE WHEN INDICATED.

Excerpted from *Hearing Screening Guidelines and Resource Manual* (January 2004)

Developmental Scales

(*To be used with* ***Risk Indicators for Hearing Loss Checklist*** *when performing KBH screens for birth through four years of age.*)

Name: ____ **Date of birth:** ____________

Child's chronological age _______________ Premature ______ months Adjusted age __________________

Does your child: (Please check questions in the appropriate age category – **use adjusted age)**

Birth to 4 months	**Yes**	**No**		**Yes**	**No**
Startle or cry to loud noises?			Respond to a familiar voice?		
Awaken to loud sounds?			Stop crying when talked to?		
Stop moving when a new sound is made?					

4 to 8 months	**Yes**	**No**		**Yes**	**No**
Stir or awaken when sleeping quietly and someone talks or makes a loud noise?			Cry when exposed to a sudden or loud sound?		
Try to turn head toward an interesting sound or when name is called?			Make several different babbling sounds?		
Listen to a soft musical toy, bell, or rattle?					

8 to 12 months	**Yes**	**No**		**Yes**	**No**
Respond in some way to the direction "no"?			Stir or awaken when sleeping quietly and someone talks or makes a loud sound?		
React to name when called?			Try to imitate you if you make familiar sounds?		
Turn head toward the side where a sound is coming from?			Use variety of different consonants and vowels when babbling (cononical babbling*)?		

12 to 18 months	**Yes**	**No**		**Yes**	**No**
Say "mama" or "dada" and imitate many words you say?			Turn head to look in the direction where the sound came from when an interesting sound is presented?		
Respond to requests such as "come here" and "do you want more"?			Wake up when there is a loud sound?		

18 to 24 months	**Yes**	**No**		**Yes**	**No**
Try to sing?			Speak at least 20 words?		
Point to several different body parts?			Request by name items such as milk or cookies?		
Respond to simple commands such as "put the ball in the box"?					

2 to 5 years	**Yes**	**No**		**Yes**	**No**
Point to a picture if you say "Where's the _________"?			Listen to TV or radio at same loudness level as other family members?		
Talk in short sentences?			Hear you when you call child's name from another room?		
Notice most sounds?					

(*Cononical babbling is defined as nonrepetitive babbling using several consonant and vowel combinations, such as "itika," "dabata," "omada." It is quite different from common babbling such as "dada," "mama," or "baba.")

Pass = All "YES" responses or only one "NO" response. Refer = Two or more "NO" responses.

Check one: Pass ☐ **Refer** ☐ **If other, explain:** ____

Screener: ____ **Date**: __________________

PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE WHEN INDICATED.

Excerpted from *Hearing Screening Guidelines and Resource Manual* (January 2004)