

4 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? _____

Has baby shown interest in solid foods? _____

Elimination:

How many wet diapers a day? _____

How many stool diapers a day? _____

Dental:

Does baby have any teeth? _____ if yes how many? _____

Sleep:

Is baby sleeping for 9-12 hours at night? _____

Does baby take naps 1-4 times a day for 30 min- 2 hrs at a time? _____

How many nighttime awakenings? _____

Behavior/Temperament

Do you have any concerns?

Development:

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

If yes, please describe:

Babies at 4 months almost all will (please circle yes or not)

- | | | |
|--|-----|----|
| - regard own hand | yes | no |
| - follow to 180 degrees | yes | no |
| - puts hand together | yes | no |
| - grasp rattle | yes | no |
| - makes ooh/aah sounds with squeals and laughs | yes | no |
| - sit with head steady | yes | no |
| - lift head to 90 degrees when on tummy | yes | no |
| - bear weight on legs | yes | no |

Some babies can

- | | | |
|---|-----|----|
| - regard a toy | yes | no |
| - imitate speech sounds | yes | no |
| - turn to a voice, turn to rattling sound | yes | no |
| - no head lag when pulled to a sitting position | yes | no |
| - roll over | yes | no |
| - chest over with supporting on arms | yes | no |

Social:

How are things going at home?



Ages & Stages Questionnaires®

4 Month Questionnaire

3 months 0 days through 4 months 30 days



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:	

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:

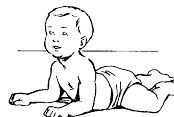
COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. After you have been out of sight, does your baby smile or get excited when he sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby stop crying when she hears a voice other than yours?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby laugh?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby make sounds when looking at toys or people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 5. When you hold him in a sitting position, does your baby hold his head steady? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



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)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you put a toy in her hand, does your baby wave it about, at least briefly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your baby grab or scratch at his clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you put a toy in her hand, does your baby look at it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. When you put a toy in his hand, does your baby put the toy in his mouth? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

PROBLEM SOLVING (continued)

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?



YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

1. Does your baby watch his hands?



YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

2. When your baby has her hands together, does she play with her fingers?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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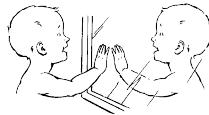
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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5. Before you smile or talk to your baby, does he smile when he sees you nearby?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------

6. When in front of a large mirror, does your baby smile or coo at herself?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------

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?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. Other concerns?
Comments: | YES | No |

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						

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.

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.