



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: _____



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?	<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)

5. When you hold him in a sitting position, does your baby hold his head steady?

YES SOMETIMES NOT YET

☐ ☐ ☐ _____

6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers?



☐ ☐ ☐ _____

GROSS MOTOR TOTAL _____

FINE MOTOR

1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)?



YES SOMETIMES NOT YET

☐ ☐ ☐ _____

2. When you put a toy in her hand, does your baby wave it about, at least briefly?

☐ ☐ ☐ _____

3. Does your baby grab or scratch at his clothes?

☐ ☐ ☐ _____

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?

☐ ☐ ☐ _____

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?

☐ ☐ ☐ _____

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?

☐ ☐ ☐ _____

FINE MOTOR TOTAL _____

PROBLEM SOLVING

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?

YES SOMETIMES NOT YET

☐ ☐ ☐ _____

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?

☐ ☐ ☐ _____

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?

☐ ☐ ☐ _____

4. When you put a toy in her hand, does your baby look at it?

☐ ☐ ☐ _____

5. When you put a toy in his hand, does your baby put the toy in his mouth?

☐ ☐ ☐ _____

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

☐
☐
☐

PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

1. Does your baby watch his hands?



YES SOMETIMES NOT YET

☐
☐
☐

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

☐
☐
☐

3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?

☐
☐
☐

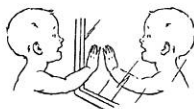
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?

☐
☐
☐

5. Before you smile or talk to your baby, does he smile when he sees you nearby?

☐
☐
☐

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


☐
☐
☐

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