

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**LEAD RISK ASSESSMENT**

**(YES OR NO ANSWERS)**

1. Does your child live in or regularly visit a house that was built before 1950, including a home child care center or the home of a relative?
2. Does your child live in or regularly visit a house built before 1978 that has been remodeled in the last 6 months? Are there any plans to remodel?
3. Does your child have a brother, sister, housemate or playmate who is being treated for lead poisoning?
4. Does your child live with an adult whose job or hobby involves exposure to lead?
5. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead into the environment?
6. Does your child live with 1 block of a major highway or busy street?
7. Has your child ever been given home remedies such as azarcon, great, or pay loah?
8. Has your child ever lived outside the United States?
9. Does your family use pottery or ceramics for cooking, eating or drinking?
10. Have you seen your child eat paint chips?
11. Have you seen your child eat soil or dirt?
12. Have you been told your child has low iron?



# Ages & Stages Questionnaires®

## 9 Month Questionnaire

9 months 0 days through 9 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: _____	



# 9 Month Questionnaire

9 months 0 days  
through 9 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:

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## COMMUNICATION



	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. If you ask your baby to, does he play at least one nursery game even if you don't show her the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				COMMUNICATION TOTAL —

## GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				




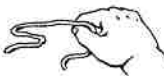

**GROSS MOTOR** (continued)

YES                      SOMETIMES                      NOT YET

- |   |   |                       |                       |                       |   |
|---|---|-----------------------|-----------------------|-----------------------|---|
| 3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support? |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?            |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?                                |   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby walk beside furniture while holding on with only one hand?  |   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
|   |   |                       | GROSS MOTOR TOTAL     |                       | — |




**FINE MOTOR**

YES                      SOMETIMES                      NOT YET


- |   |   |                       |                       |                       |    |
|---|---|-----------------------|-----------------------|-----------------------|----|
| 1. Does your baby pick up a small toy with only one hand?   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —  |
| 2. Does your baby successfully pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.) |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —  |
| 3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)  |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —  |
| 4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —  |
| 5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.  |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —* |
| 6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?  |   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | —  |
|   |   |                       | FINE MOTOR TOTAL      |                       | —  |

\*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

**PROBLEM SOLVING**

		YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. When holding a toy in his hand, does your baby bang it against another toy on the table?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PROBLEM SOLVING TOTAL					—

**PERSONAL-SOCIAL**

		YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby drink water, juice, or formula from a cup while you hold it?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby feed himself a cracker or a cookie?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?		<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

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

**OVERALL** (continued)

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



# 9 Month ASQ-3 Information Summary

9 months 0 days through  
9 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	13.97		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	17.82		●	●	●	●	○	○	○	○	○	○	○	○	○
Fine Motor	31.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	28.72		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	18.91		●	●	●	●	○	○	○	○	○	○	○	○	○

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