10 months

Please complete these forms before your visit today.

Thank you!

ASQ-3 Ages & Stages Questionnaires®

10 Month Questionnaire

9 months 0 days through 10 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	____
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	____
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	____
4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	○	○	○	____
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures?	○	○	○	____
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.)*	○	○	○	____

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? 	○	○	○	____
2. When sitting on the floor, does your baby sit up straight for several minutes *without* using his hands for support? 	○	○	○	____

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? 	○	○	○	____
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? 	○	○	○	____
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	○	○	○	____
6. Does your baby walk beside furniture while holding on with only one hand?	○	○	○	____

GROSS MOTOR TOTAL ____

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand? 	○	○	○	____
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.)* 	○	○	○	____
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.)* 	○	○	○	____
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.)* 	○	○	○	____
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. 	○	○	○	____*
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	○	○	○	____

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? 	○	○	○	___
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	○	○	○	___
3. When holding a toy in his hand, does your baby bang it against another toy on the table? 	○	○	○	___
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	○	○	○	___
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)?	○	○	○	___
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.)*	○	○	○	___

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? 	○	○	○	___
2. Does your baby drink water, juice, or formula from a cup while you hold it?	○	○	○	___
3. Does your baby feed himself a cracker or a cookie?	○	○	○	___
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.)*	○	○	○	___
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?	○	○	○	___
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

State of California — H **Staying Healthy Assessment**
7-12 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐Guardian ☐ Other (specify)			Need Help with Form ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you breastfeed your baby?	Yes	No	Skip	*Nutrition*
2	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Are you concerned about your baby's weight?	No	Yes	Skip	*Physical Activity*
4	Does your baby watch any TV?	No	Yes	Skip	
5	Does your home have a working smoke detector?	Yes	No	Skip	*Safety*
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
8	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always put your baby to sleep on his/her back?	Yes	No	Skip	
11	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
12	Do you always place your baby in a rear-facing car seat in the back seat?	Yes	No	Skip	
13	Is the car seat you use the correct one for the age and size of your baby?	Yes	No	Skip	
14	Does your baby spend time near a swimming pool, river, or lake?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	*Dental Health*

17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	*Drug, Alcohol & Tobacco Exposure*
18	Does your child have any family members who have or have had a problem with alcohol or other drugs?	No	Yes	Skip	
19	Does your child have any family members who suffer from depression, anxiety, PTSD or other mental health conditions?	No	Yes	Skip	*Home Environment*
20	(For parents) Does a partner, or anyone at home, hurt, hit or threaten you?	No	Yes	Skip	
21	Has your child ever been away from either parent due to parental illness, separation, foster care, parental incarceration or other reasons?	No	Yes	Skip	
22	Has anything really scary or upsetting happened to your child or anyone in your family?	No	Yes	Skip	
23	In the last year, have you been worried that your food would run out before you were able to get more?	No	Yes	Skip	*Other Questions*
24	In the last year, have you been worried that you would need to move out of a place you were staying due to inability to afford the rent, or for other reasons?	No	Yes	Skip	
25	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Drug, Alcohol & Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**
☐ Home Environment	☐	☐	☐	☐	
PCP's Signature:		Print Name:			Date:

GARDNER
Packard Children's Health Center

Family Needs Screening[1,2]

Our goal at Gardner Packard Children's Health Center is to provide the best possible care for your child and family. We would like to make sure you know resources available to you for your family's needs. Please answer both questions and give to your child's doctor at the beginning of the visit. Thank You!

1. Which of these would you like help with today? (Check all that apply)

   - ❑ Food
   - ❑ Housing
   - ❑ Living conditions (like mold in your home)
   - ❑ Utilities
   - ❑ Transportation
   - ❑ Tutoring or Homework Help
   - ❑ Childcare or preschool

   - ❑ None of these

2. Which of the concerns above is most important to talk about today?

Adapted from: [1] Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health Related Social Needs Screening Tool and [2] WE-CARE: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education. Modified on 6/12/2018.