8 months

Please complete these forms before your visit today.

Thank you!

ASQ-3 Ages & Stages Questionnaires®

8 Month Questionnaire

7 months 0 days through 8 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. If you call to your baby when you are out of sight, does she look in the direction of your voice?	○	○	○	____
2. When a loud noise occurs, does your baby turn to see where the sound came from?	○	○	○	____
3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	____
4. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	____
5. Does your baby respond to the tone of your voice and stop his activity at least briefly when you say "no-no" to him?	○	○	○	____
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	____

COMMUNICATION TOTAL ____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. When you put your baby on the floor, does she lean on her hands while sitting? *(If she already sits up straight without leaning on her hands, mark "yes" for this item.)* 	○	○	○	____
2. Does your baby roll from his back to his tummy, getting both arms out from under him?	○	○	○	____

GROSS MOTOR *(continued)*

		YES	SOMETIMES	NOT YET	
3. Does your baby get into a crawling position by getting up on her hands and knees?		○	○	○	____
4. If you hold both hands just to balance your baby, does he support his own weight while standing?		○	○	○	____
5. When sitting on the floor, does your baby sit up straight for several minutes *without* using her hands for support?		○	○	○	____*
6. When you stand your baby next to furniture or the crib rail, does he hold on without leaning his chest against the furniture for support?		○	○	○	____

GROSS MOTOR TOTAL ____

**If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."*

FINE MOTOR

		YES	SOMETIMES	NOT YET	
1. Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? *(If she already picks up a small object, mark "yes" for this item.)*		○	○	○	____
2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?		○	○	○	____
3. Does your baby *try* to pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion, even if she isn't able to pick it up? *(If she already picks up a crumb or Cheerio, mark "yes" for this item.)*		○	○	○	____
4. Does your baby pick up a small toy with only one hand?		○	○	○	____

FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. Does your baby *successfully* pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion? *(If he already picks up a crumb or Cheerio, mark "yes" for this item.)* 	○	○	○	____
6. Does your baby pick up a small toy with the *tips* of her thumb and fingers? *(You should see a space between the toy and her palm.)* 	○	○	○	____*

FINE MOTOR TOTAL ____

**If Fine Motor Item 6 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a toy and put it in his mouth? 	○	○	○	____
2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	____
3. Does your baby play by banging a toy up and down on the floor or table? 	○	○	○	____
4. Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	____
5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	○	○	○	____
6. When holding a toy in his hand, does your baby bang it against another toy on the table? 	○	○	○	____

PROBLEM SOLVING TOTAL ____

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When lying on her back, does your baby play by grabbing her foot? 	○	○	○	____
2. When in front of a large mirror, does your baby reach out to pat the mirror? 	○	○	○	____
3. Does your baby try to get a toy that is out of reach? *(He may roll, pivot on his tummy, or crawl to get it.)*	○	○	○	____
4. While your baby is on her back, does she put her foot in her mouth? 	○	○	○	____
5. Does your baby drink water, juice, or formula from a cup while you hold it?	○	○	○	____
6. Does your baby feed himself a cracker or a cookie?	○	○	○	____

PERSONAL-SOCIAL TOTAL ____

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.