



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: _____

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. If you call to your baby when you are out of sight, does she look in the direction of your voice? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. When a loud noise occurs, does your baby turn to see where the sound came from? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 3. 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"/> | _____ |
| 4. Does your baby make sounds like "da," "ga," "ka," and "ba"? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 6. 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"/> | _____ |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |
| 2. Does your baby roll from his back to his tummy, getting both arms out from under him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____ |



GROSS MOTOR

(continued)

3. Does your baby get into a crawling position by getting up on her hands and knees?



YES

☐

SOMETIMES

☐

NOT YET

☐

—

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

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.)



YES

☐

SOMETIMES

☐

NOT YET

☐

—

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)

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.)



YES

☐

SOMETIMES

☐

NOT YET

☐

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

1. Does your baby pick up a toy and put it in his mouth?



YES

☐

SOMETIMES

☐

NOT YET

☐

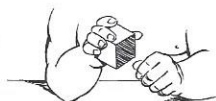
2. When your baby is on her back, does she try to get a toy she has dropped if she can see it?

☐☐☐

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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 2. When in front of a large mirror, does your baby reach out to pat the mirror? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 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.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. While your baby is on her back, does she put her foot in her mouth? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| |  | | | |
| 5. Does your baby drink water, juice, or formula from a cup while you hold it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby feed himself a cracker or a cookie? | <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