



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.

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

Relationship to baby:
 Parent Guardian
 Grandparent or other relative Foster parent

Other: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

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 him the activity yourself (such as "bye-bye," "Peek-a-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?



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.




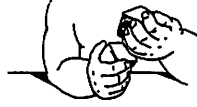

 _____*

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?		<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

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

Child's Name: _____ Date of Birth: _____



Division of Public Health,
Prevention Services Branch
Tuberculosis Program
404-657-2634 fax: 404-463-3460
<http://health.state.ga.us/programs/tb>

Tuberculosis (TB) Risk Assessment

Child Health Services

Circle Yes or No.

- | | | |
|---|-----|----|
| 1. Is the child in close contact to a person sick with active TB disease? * | Yes | No |
| 2. Does the child have or is at risk to have HIV? | Yes | No |
| 3. Was the child or the child's parent born outside the US? | Yes | No |
| 4. Is the child exposed to a person in jail or a person who has been in jail in the past five years? | Yes | No |
| 5. Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home? | Yes | No |
| 6. Is the child exposed to drug users or migrant farm workers? | Yes | No |
| 7. Does the child have a health problem that lowers the immune system? | Yes | No |
| 8. Does the child live in a community that has a high risk for TB? | Yes | No |
| 9. Has the child traveled to or had a visitor from any foreign country since the last visit? | Yes | No |
| 10. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or an abnormal chest x-ray?* | Yes | No |

* Call the Health Department

Any 'yes' answer means the child is High Risk and should have a Mantoux TB skin test. The test should be read by a Health Professional.

For your child's health, this form is required to be completed at the following visits:

DPH06/057W

1 month

6 month

12 month

18 month

Rev. 08.2006

2 year through 18 year

**PARENTS
PLEASE
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BEYOND
THIS
PAGE**



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