CASTLE VALLEY CHILDRENS' CLINIC

Health Maintenance Visit

4 MO - 6 MO

Patient Name _____

PARENT: PLEASE FILL OUT THIS SIDE DOWN TO THE DOUBLE LINE (please circle and check appropriate answers

NUTRITION

1. Are you breastfeeding or bottlefeeding your baby now? Breast Bottle
2. Are you giving your baby vitamins, iron or fluoride? yes no
3. Please check kind of food and approximately how much your baby eats:
   Formula _____ Kind_____ How many ounces in a 24 hour period? _____
   Juice_____ How many ounces in a 24 hour period? _____
   Cereal_____ Amount (Table spoons)_____ Fruits_____ Amount _____
   Vegetables ____ Amount_____ Meats_____ Amount _____
   Other_____
4. Are you feeding your baby with a spoon? yes no
5. Do you ever use an infant feeder? yes no
6. Is your baby having any problems with eating? yes no
7. Is your child on WIC or Denver Food Supplemental Program? yes no

ELIMINATION

8. How many wet diapers does your baby have in a 24 hour period? _____
9. How many bowel movements (stools) does your baby have in a 24 hour period? _____
10. Has your child had any problems with constipation or diarrhea? yes no

BEHAVIOR

11. Is your child having any problems with sleeping? yes no
12. How many hours does your baby sleep at one time? _____ hours
13. Does your child have any behaviors you would like to change? yes no
    List Behavior_____
14. Is there anything which upsets you or concerns you about your child? yes no
    What is it? _____
15. Does you feel you have a difficult child? yes no

DEVELOPMENT

16. All children learn things at different times. At this point in your child's development, check which of the following he/she can do.

_____Hold head steady _____ High pitched squeals _____ Make noises besides crying _____ Smile with you
_____Laugh with you _____ Reach for objects _____ Bear weight on legs _____Roll over _____

ILLNESS

17. Has your baby had any illnesses or needed to see a doctor since your last visit? yes no
18. If your child is on any medications, please name them: _____

REVIEW OF SYSTEMS (Check if your child has any of the following since the last visit.)

____ Accidents or head injury ____Eye drainage ____Colds/coughing ____Convulsion or seizure
____Nasal congestion ____ High fever ____Ear infection/earache ____Trouble breathing
____ Skin rashes ____ Crossed eyes ____Trouble finishing a feeding ____Recent change-home/family

---

OBJECTIVE:

_____

NURSING DIAGNOSIS:

_____

PLAN: (Anticipatory guidance checklist on page 1)

PROVIDER SIGNATURE _____

ASQ-3 Ages & Stages Questionnaires®

5 months 0 days through 6 months 30 days

6 Month Questionnaire

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: _____

P101060100

ASQ-3 6 Month Questionnaire

5 months 0 days through 6 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:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make high-pitched squeals?	○	○	○	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	○	○	○	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	○	○	○	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	○	○	○	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	○	○	○	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	○	○	○	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	○	○	○	___
4. 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.)* 	○	○	○	___

E101060200

GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. If you hold both hands just to balance your baby, does he support his own weight while standing? 	○	○	○	___
6. Does your baby get into a crawling position by getting up on her hands and knees? 	○	○	○	___
		GROSS MOTOR TOTAL		___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?	○	○	○	___
2. Does your baby reach for or grasp a toy using both hands at once?	○	○	○	___
3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? *(If he already picks up a small object the size of a pea, mark "yes" for this item.)* 	○	○	○	___
4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it? 	○	○	○	___
5. Does your baby *try* to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? *(If he already picks up the crumb or Cheerio, mark "yes" for this item.)* 	○	○	○	___
6. Does your baby pick up a small toy with only one hand? 	○	○	○	___
		FINE MOTOR TOTAL		___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When a toy is in front of your baby, does she reach for it with both hands?	○	○	○	___
2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*	○	○	○	___
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___
				___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth? 	○	○	○	___
5. Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	___
6. Does your baby play by banging a toy up and down on the floor or table? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When in front of a large mirror, does your baby smile or coo at herself? 	○	○	○	___
2. Does your baby act differently toward strangers than he does with you and other familiar people? *(Reactions to strangers may include staring, frowning, withdrawing, or crying.)*	○	○	○	___
3. While lying on her back, does your baby play by grabbing her foot? 	○	○	○	___
4. When in front of a large mirror, does your baby reach out to pat the mirror? 	○	○	○	___
5. While your baby is on his back, does he put his foot in his mouth? 	○	○	○	___
6. Does your baby try to get a toy that is out of reach? *(She may roll, pivot on her tummy, or crawl to get it.)*	○	○	○	___

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

6 Month ASQ-3 Information Summary

5 months 0 days through 6 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	29.65		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Gross Motor	22.25		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Fine Motor	25.14		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Problem Solving	27.72		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Personal-Social	25.34		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯

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

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						

P101060700