CASTLE VALLEY CHILDREN'S CLINIC
HEALTH MAINTENANCE VISIT
NEWBORN-2 MONTHS

Patient name: _____

PREGNANCY AND BIRTH

1. ***Did you have any illness or take any medication/drugs during pregnancy?..... YES NO***
2. ***Did you carry your baby for a full nine months?.....YES NO***
3. ***Baby's birth weight?*** _____
4. ***Did your baby have any problems while in the hospital? .....YES NO***

NUTRITION

5. ***Do you breast feed or bottle feed your baby?.....Breast Bottle***
6. ***How many times a day (24 HRS) does your baby breastfeed or take a bottle?*** _____
7. ***If bottle feeding, how many ounces does your baby drink each feeding?*** _____
8. ***If bottle feeding, what kind of formula do you use?*** _____
9. ***Does your baby take any other kinds of fluids besides milk? ..... YES NO***
10. ***Is your baby on cereal or baby foods? ..... YES NO***
11. ***Are you giving your baby vitamins, iron, or fluoride drops?..... YES NO***
12. ***Is your baby having any problems with feeding? ..... YES NO***

ELIMINATION

13. ***How many bowel movements (stools) does your baby have in a 24 hour period?*** _____
14. ***Are the stools: (circle) Watery? Soft and pasty? Formed? Like hard pellets?***

BEHAVIOR

15. ***Does your baby have any problems with sleeping?..... YES NO***
16. ***All babies cry. How much does your baby cry? (check) ___Very Little ____Some ____ A lot***
17. ***Is there anything that upsets you or concerns you about your baby?.....YES NO***
18. ***Do you feel you have a difficult child?.....YES NO***

DEVELOPMENT

Children learn different things as they grow. At this point in your child's development, which of the following can he/she do? (Please Check)

_____ ***Smiles*** _____ ***Make noises besides crying*** _____ ***Lifts up head while on stomach***
_____ ***Follows your movements by turning head from one side almost all the way to the other.***

ILLNESSES

19. ***Has your baby had any illnesses or needed to see a Doctor since birth? ..... YES NO***
20. ***Is your baby on any medications?..... YES NO***

REVIEW OF SYSTEMS (Check if your child has had any of the following:)

____ ***Convulsion or seizure*** ____ ***Crossed Eyes*** ____ ***Difficulty finishing a feeding*** ____ ***Eye drainage***
____ ***Head Injury*** ____ ***Stuffy nose*** ____ ***High Fever*** ____ ***Recent change in home/family***
____ ***Ear infection/earache*** ____ ***Trouble Breathing*** ____ ***Skin Rash*** ____ ***Turning blue***

Any question you have for us? _____

ASQ-3 Ages & Stages Questionnaires®

1 month 0 days through 2 months 30 days

2 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: _____

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ASQ-3

2 Month Questionnaire

1 month 0 days through 2 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 sometimes make throaty or gurgling sounds?	○	○	○	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	○	○	○	___
3. When you speak to your baby, does she make sounds back to you?	○	○	○	___
4. Does your baby smile when you talk to him?	○	○	○	___
5. Does your baby chuckle softly?	○	○	○	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	○	○	○	___
2. When your baby is on her tummy, does she turn her head to the side?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	○	○	○	___
4. When your baby is on her back, does she kick her legs?	○	○	○	___
5. While your baby is on his back, does he move his head from side to side?	○	○	○	___
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	○	○	○	___

GROSS MOTOR TOTAL ___

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FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Is your baby's hand usually tightly closed when he is awake? (*If your baby used to do this but no longer does, mark "yes."*)	○	○	○	___
2. Does your baby grasp your finger if you touch the palm of her hand? 	○	○	○	___
3. When you put a toy in his hand, does your baby hold it in his hand briefly? 	○	○	○	___
4. Does your baby touch her face with her hands?	○	○	○	___
5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? 	○	○	○	___ *
6. Does your baby grab or scratch at her clothes?	○	○	○	___

FINE MOTOR TOTAL ___

**If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby look at objects that are 8–10 inches away?	○	○	○	___
2. When you move around, does your baby follow you with his eyes?	○	○	○	___
3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head?	○	○	○	___
4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?	○	○	○	___
5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?	○	○	○	___
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	○	○	○	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	○	○	○	___
3. Does your baby smile at you?	○	○	○	___
4. When you smile at your baby, does she smile back?	○	○	○	___
5. Does your baby watch his hands? 	○	○	○	___
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Did your baby pass the newborn hearing screening test? If no, explain: ○ YES ○ NO

2. Does your baby move both hands and both legs equally well? If no, explain: ○ YES ○ NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: ○ YES ○ NO

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OVERALL *(continued)*

4. Has your baby had any medical problems? If yes, explain: ○ YES ○ NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain: ○ YES ○ NO

6. Does anything about your baby worry you? If yes, explain: ○ YES ○ NO

2 Month ASQ-3 Information Summary

1 months 0 days through 2 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	22.77		●	●	●	●	●	○	○	○	○	○	○	○	○
Gross Motor	41.84		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	30.16		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	24.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	33.71		●	●	●	●	●	●	●	○	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Passed newborn hearing screening test? Yes **NO**
   Comments:

2. Moves both hands and both legs equally well? Yes **NO**
   Comments:

3. Family history of hearing impairment? **YES** No
   Comments:

4. Any medical problems? **YES** No
   Comments:

5. Concerns about behavior? **YES** No
   Comments:

6. 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						

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