Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By **Diane Bricker** and **Jane Squires**
with assistance from ***Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly,*** *and* ***Jane Farrell***

• 10 Month • Questionnaire

On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Be sure to try each activity with your child before checking a box.
- ☑ Try to make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested, fed, and ready to play.
- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Look forward to filling out another questionnaire in _____ months.

ASQ™

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• 10 Month • Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

_____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

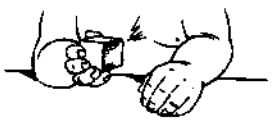
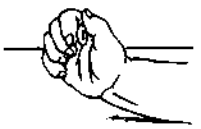
_____

Administering program or provider: _____

ASQ™

	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	❑	❑	❑	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	❑	❑	❑	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (He may say these sounds without referring to any particular object or person.)	❑	❑	❑	___
4. If you ask her to, does your baby play at least one nursery game even if you don't show her the activity yourself (e.g., "bye-bye," "Peekaboo," "clap your hands," "So Big")?	❑	❑	❑	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures?	❑	❑	❑	___
6. Does your baby say one word in addition to "Mama" and "Dada"? (A "word" is a sound or sounds the baby says consistently to mean someone or something, such as "baba" for bottle.)	❑	❑	❑	___
		COMMUNICATION TOTAL		___

GROSS MOTOR *Be sure to try each activity with your child.*				
1. If you hold both hands just to balance her, does your baby support her own weight while standing? 	❑	❑	❑	___
2. When sitting on the floor, does your baby sit up straight for several minutes *without* using his hands for support? 	❑	❑	❑	___
3. When you stand her next to furniture or the crib rail, does your baby 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 along furniture while holding on with only one hand?	❑	❑	❑	___
		GROSS MOTOR TOTAL		___

	YES	SOMETIMES	NOT YET	
FINE MOTOR *Be sure to try each activity with your child.*				
1. Does your baby pick up small toys with only one hand? 	❑	❑	❑	___
2. Does your baby *successfully* pick up a crumb or Cheerio by using her thumb and all her fingers in a raking motion? (If she already picks up a crumb or Cheerio, check "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 set 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 as "yes."*

PROBLEM SOLVING *Be sure to try each activity with your child.*				
1. Does your baby pass a toy back and forth from one hand to the other? 	❑	❑	❑	___
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	❑	❑	❑	___
3. When holding a toy in his hand, does your baby bang it against another toy on the table? 	❑	❑	❑	___
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	❑	❑	❑	___

	YES	SOMETIMES	NOT YET	

PROBLEM SOLVING *(continued)*

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)?	❑	❑	❑	___
6. After he watches you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)	❑	❑	❑	___
		PROBLEM SOLVING TOTAL		___

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. While on her back, does your baby put her foot in her mouth? 	❑	❑	❑	___
2. Does your baby drink water, juice, or formula from a cup while you hold it?	❑	❑	❑	___
3. Does your baby feed himself a cracker or a cookie?	❑	❑	❑	___
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, check "yes" for this item.)	❑	❑	❑	___
5. When you dress him, does your baby push his arm through a sleeve once his arm is started in the hole of the sleeve?	❑	❑	❑	___
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	❑	❑	❑	___
		PERSONAL-SOCIAL TOTAL		___

OVERALL *Parents and providers may use the bottom of the next sheet for additional comments.*

1. Do you think your child hears well? YES ❑ NO ❑
   If no, explain: _____
2. Does your baby use both hands equally well? YES ❑ NO ❑
   If no, explain: _____
3. When you help your baby stand, are his feet flat on the surface most of the time? YES ❑ NO ❑
   If no, explain: _____
4. Does either parent have a family history of childhood deafness or hearing impairment? YES ❑ NO ❑
   If yes, explain: _____

OVERALL *(continued)*

5. Do you have any concerns about your child's vision? YES ❑ NO ❑

   If yes, explain: _____

6. Has your child had any medical problems in the last several months? YES ❑ NO ❑

   If yes, explain: _____

7. Does anything about your child worry you? YES ❑ NO ❑

   If yes, explain: _____

10 Month ASQ Information Summary

Child's name: _____ Date of birth: _____

Person filling out the ASQ: _____ Corrected date of birth: _____

Mailing address: _____ Relationship to child: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ completion: _____

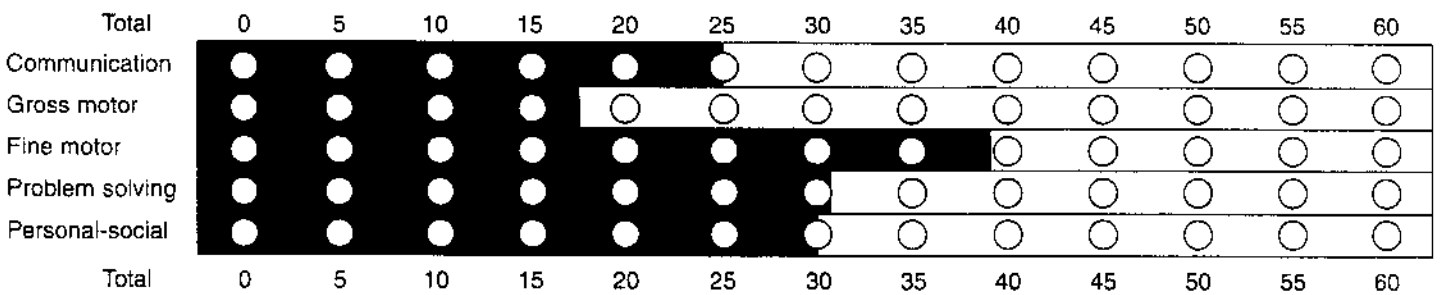
Today's date: _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1. Hears well? YES NO
   Comments:
2. Uses both hands equally well? YES NO
   Comments:
3. Baby's feet flat on the surface? YES NO
   Comments:
4. Family history of hearing impairment? YES NO
   Comments:
5. Vision concerns? YES NO
   Comments:
6. Recent medical problems? YES NO
   Comments:
7. Other concerns? YES NO
   Comments:

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide*.
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the ▭ area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the ■ area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

10 months

	Score	Cutoff
Communication		25.0
Gross motor		17.5
Fine motor		39.0
Problem solving		30.5
Personal-social		30.0

	Communication	Gross motor	Fine motor	Problem solving	Personal-social
1	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
2	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
3	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
4	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
5	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
6	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○	○ ○ ○
	Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____

Bright Futures Medical Screening Questionnaire
9 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	Y	N	Unsure
Do your child's eyelids droop or does one eyelid tend to close?	Y	N	Unsure
Have your child's eyes ever been injured?	Y	N	Unsure
Does your child have a sibling or playmate who has or had lead poisoning?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1950?	Y	N	Unsure
Are cavities a problem for you or anyone else in your family?	Y	N	Unsure
Does your child sleep with a bottle?	Y	N	Unsure
Does your child continuously breastfeed through the night?	Y	N	Unsure