




YES      SOMETIMES      NOT YET

**COMMUNICATION**      *Be sure to try each activity with your child.*

- |   |                          |                          |                          |     |
|---|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your baby make high-pitched squeals?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. If you call your baby when you are out of sight, does she look in the direction of your voice? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. When a loud noise occurs, does your baby turn to see where the sound came from?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your baby make sounds like "da," "ga," "ka," and "ba"?                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. If you copy the sounds your baby makes, does your baby repeat the sounds back to you?          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| COMMUNICATION TOTAL   |                          |                          |                          | ___ |

**GROSS MOTOR**      *Be sure to try each activity with your child.*


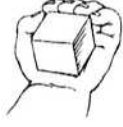


- |  |   |                          |                          |     |
|--|---|--------------------------|--------------------------|-----|
| 1. While on his back, does your baby lift his legs high enough to see his feet?  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. When she is on her tummy, does your baby straighten both arms and push her whole chest off the bed or floor?  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3. Does your baby roll from his back to his tummy, getting both arms out from under him?   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. When you put her on the floor, does your baby lean on her hands while sitting? (If she already sits up straight without leaning on her hands, check "yes" for this item.) | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|  |  |                          |                          |     |
| 5. If you hold both hands just to balance him, does your baby support his own weight while standing?   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|  |  |                          |                          |     |
| 6. Does your baby get into a crawling position by getting up on her hands and knees?   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|  |  |                          |                          |     |
| GROSS MOTOR TOTAL  |   |                          |                          | ___ |

**FINE MOTOR**      *Be sure to try each activity with your child.*


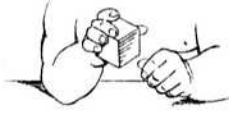

- |   |                          |                          |                          |     |
|---|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|---|--------------------------|--------------------------|--------------------------|-----|

YES      SOMETIMES      NOT YET

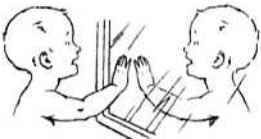





**FINE MOTOR**      *(continued)*

- |                  |  |                          |                          |                          |     |
|------------------|--|--------------------------|--------------------------|--------------------------|-----|
| 2.               | Does your baby reach for or grasp a toy using both hands at once?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3.               | Does your baby reach for a crumb or Cheerio and touch it with his finger? (If he already picks up a small object the size of a pea, check "yes" for this item.)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                  |   |                          |                          |                          |     |
| 4.               | Does your baby pick up a small toy, holding it in the center of her hands with her fingers around it?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                  |   |                          |                          |                          |     |
| 5.               | Does your baby try to pick up a crumb or Cheerio by using his thumb and all 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, check "yes" for this item.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                  |   |                          |                          |                          |     |
| 6.               | Does your baby usually pick up a small toy with only one hand?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                  |   |                          |                          |                          |     |
| FINE MOTOR TOTAL |  |                          |                          |                          | ___ |

**PROBLEM SOLVING**      *Be sure to try each activity with your child.*

- |                       |  |                          |                          |                          |     |
|-----------------------|--|--------------------------|--------------------------|--------------------------|-----|
| 1.                    | When a toy is in front of her, does your baby reach for it with both hands?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2.                    | When he is on his back, does your baby turn his head to look for a toy when he drops it? (If he already picks it up, check "yes" for this item.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 3.                    | When she is on her back, does your baby try to get a toy she has dropped if she can see it?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4.                    | Does your baby often pick up toys and put them in his mouth?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                       |   |                          |                          |                          |     |
| 5.                    | Does your baby pass a toy back and forth from one hand to the other?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                       |   |                          |                          |                          |     |
| 6.                    | Does your baby play by banging a toy up and down on the floor or table?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
|                       |   |                          |                          |                          |     |
| PROBLEM SOLVING TOTAL |  |                          |                          |                          | ___ |

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

- |  |   |                          |                          |                          |      |
|--|---|--------------------------|--------------------------|--------------------------|------|
| <p>1. When in front of a large mirror, does your baby smile or coo at herself?</p>   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____ |
| <p>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.)</p> |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____ |
| <p>3. While lying on her back, does your baby play by grabbing her foot?</p>   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____ |
| <p>4. When in front of a large mirror, does your baby reach out to pat the mirror?</p>   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____ |
| <p>5. While on his back, does your baby put his foot in his mouth?</p>   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____ |
| <p>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.)</p>  |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____ |
| <p>PERSONAL-SOCIAL TOTAL</p>   |   |                          |                          |                          | ____ |

**OVERALL**      *Parents and providers may use the back of this sheet for additional comments.*

- |   |  |
|---|--|
| <p>1. Do you think your child hears well?</p> <p>If no, explain: _____</p>  | <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> |
| <p>2. Does your baby use both hands equally well?</p> <p>If no, explain: _____</p>  | <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> |
| <p>3. When you help your baby stand, are his feet flat on the surface most of the time?</p> <p>If no, explain: _____</p>      | <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> |
| <p>4. Does either parent have a family history of childhood deafness or hearing impairment?</p> <p>If yes, explain: _____</p> | <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> |
| <p>5. Do you have concerns about your child's vision?</p> <p>If yes, explain: _____</p>                                       | <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> |
| <p>6. Has your child had any medical problems in the last several months?</p> <p>If yes, explain: _____</p>                   | <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> |
| <p>7. Does anything about your child worry you?</p> <p>If yes, explain: _____</p>   | <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> |