






YES      SOMETIMES      NOT YET

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

- |  |                          |                          |                          |     |
|--|--------------------------|--------------------------|--------------------------|-----|
| 1. If you call to your baby when you are out of sight, does he look in the direction of your voice?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. 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"/> | ___ |
| 3. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 4. Does your baby make sounds like "da," "ga," "ka," and "ba"?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 5. Does your baby respond to the tone of your voice and stop her activity at least briefly when you say "no-no" to her?                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 6. 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

COMMUNICATION TOTAL      \_\_\_

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


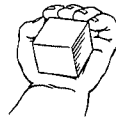
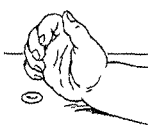
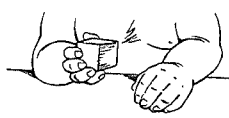
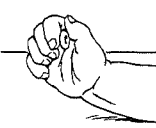
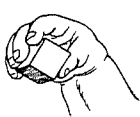
- |  |   |                          |                          |                          |       |
|--|---|--------------------------|--------------------------|--------------------------|-------|
| 1. When you put her on the floor, does your baby lean on her hands while sitting? (If she already sits up straight without leaning on her hands, check "yes" for this item.) |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___   |
| 2. 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"/> | ___   |
| 3. 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"/> | ___   |
| 4. 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"/> | ___   |
| 5. When sitting on the floor, does your baby sit up straight for several minutes <i>without</i> using her hands for support?   |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ * |
| 6. When you stand him next to furniture or the crib rail, does your baby hold on without leaning his chest against the furniture for support?                                |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___   |

GROSS MOTOR TOTAL      \_\_\_

*"If gross motor item 5 is marked "yes" or "sometimes," mark gross motor item 1 as "yes."*

YES      SOMETIMES      NOT YET



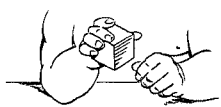
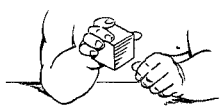
**FINE MOTOR**      *Be sure to try each activity with your child.*

- |  |   |                          |                          |                          |      |
|--|---|--------------------------|--------------------------|--------------------------|------|
| 1. Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? (If she already picks up a small object, check "yes" for this item.)  |    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___  |
| 2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?  |    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___  |
| 3. Does your baby <i>try</i> to pick up a crumb or Cheerio by using her thumb and all her fingers in a raking motion, even if she isn't able to pick it up? (If she already picks up a crumb or Cheerio, check "yes" for this item.) |    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___  |
| 4. Does your baby pick up small toys with only one hand?   |    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___  |
| 5. Does your baby <i>successfully</i> pick up a crumb or Cheerio by using his thumb and all his fingers in a raking motion? (If he already picks up a crumb or Cheerio, check "yes" for this item.)                                  |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___  |
| 6. Does your baby pick up a small toy with the <i>tips</i> of her thumb and fingers? (You should see a space between the toy and her palm.)  |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___* |

FINE MOTOR TOTAL

*\*If fine motor item 6 is marked "yes" or "sometimes," mark fine motor item 2 as "yes."*

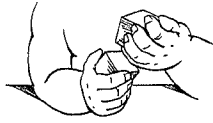
**PROBLEM SOLVING**      *Be sure to try each activity with your child.*

- |  |   |                          |                          |                          |     |
|--|---|--------------------------|--------------------------|--------------------------|-----|
| 1. Does your baby pick up a toy and put it in his mouth?                                       |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |
| 2. 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"/> | ___ |
| 3. 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"/> | ___ |
| 4. Does your baby pass a toy back and forth from one hand to the other?                        |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___ |

YES      SOMETIMES      NOT YET

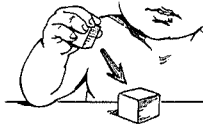
**PROBLEM SOLVING**      *(continued)*

5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?



                 \_\_\_\_\_

6. When holding a toy in his hand, does your baby bang it against another toy on the table?



                 \_\_\_\_\_

PROBLEM SOLVING TOTAL \_\_\_\_\_

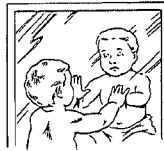
**PERSONAL-SOCIAL**      *Be sure to try each activity with your child.*

1. While lying on her back, does your baby play by grabbing her foot?



                 \_\_\_\_\_

2. When in front of a large mirror, does your baby reach out to pat the mirror?



                 \_\_\_\_\_

3. Does your baby try to get a toy that is out of reach? (He may roll, pivot on his tummy, or crawl to get it.)

                 \_\_\_\_\_

4. While on her back, does your baby put her foot in her mouth?



                 \_\_\_\_\_

5. Does your baby drink water, juice, or formula from a cup while you hold it?

                 \_\_\_\_\_

6. Does your baby feed himself a cracker or a cookie?

                 \_\_\_\_\_

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 her feet flat on the surface most of the time?      YES       NO

If no, explain: \_\_\_\_\_

**OVERALL** (continued)

4. Does either parent have a family history of childhood deafness or hearing impairment? YES  NO

If yes, explain: \_\_\_\_\_

5. Do you have 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: \_\_\_\_\_