	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. Does your baby chuckle softly?	❑	❑	❑	___
2. After you have been out of sight, does your baby stop crying when he sees you?	❑	❑	❑	___
3. Does your baby stop crying when she hears a voice other than yours?	❑	❑	❑	___
4. Does your baby make high-pitched squeals?	❑	❑	❑	___
5. Does your baby laugh?	❑	❑	❑	___
6. Does your baby make sounds when looking at toys or people?	❑	❑	❑	___
			COMMUNICATION TOTAL	___
GROSS MOTOR *Be sure to try each activity with your child.*				
1. While on his back, does your baby move his head from side to side?	❑	❑	❑	___
2. 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?	❑	❑	❑	___
3. When he is on his tummy, does your baby hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds? 	❑	❑	❑	___
4. When she is on her tummy, does your baby hold her head straight up, looking around? (She can rest on her arms while doing this.) 	❑	❑	❑	___
5. When you hold him in a sitting position, does your baby hold his head steady?	❑	❑	❑	___
6. While on her back, does your baby bring her hands together over her chest, touching her fingers? 	❑	❑	❑	___
			GROSS MOTOR TOTAL	___
FINE MOTOR *Be sure to try each activity with your child.*				
1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? 	❑	❑	❑	___
2. When you put a toy in her hand, does your baby wave it about, at least briefly?	❑	❑	❑	___
3. Does your baby grab or scratch at his clothes?	❑	❑	❑	___

	YES	SOMETIMES	NOT YET	
FINE MOTOR *(continued)*				
4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?	❑	❑	❑	____
5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?	❑	❑	❑	____
6. When you hold her in a sitting position, does your baby reach for a toy on a table close by, even though her hand may not touch it?	❑	❑	❑	____
			FINE MOTOR TOTAL	____

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

1. When you move a toy slowly from side to side in front of his face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?	❑	❑	❑	____
2. When you move a small toy up and down slowly in front of her face (about 10 inches away), does your baby follow the toy with her eyes?	❑	❑	❑	____
3. When you hold him in a sitting position, does your baby look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?	❑	❑	❑	____
4. When you put a toy in her hand, does your baby look at it?	❑	❑	❑	____
5. When you put a toy in his hand, does your baby put the toy in his mouth?	❑	❑	❑	____
6. When you dangle a toy above her while she is lying on her back, does your baby wave her arms toward the toy? 	❑	❑	❑	____
		PROBLEM SOLVING TOTAL		____

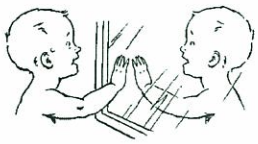
PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. Does your baby watch his hands? 	❑	❑	❑	____
2. When she has her hands together, does your baby play with her fingers?	❑	❑	❑	____
3. When he sees the breast or bottle, does your baby know he is about to be fed?	❑	❑	❑	____
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?	❑	❑	❑	____

	YES	SOMETIMES	NOT YET	

PERSONAL-SOCIAL *(continued)*

5. Before you smile or talk to him, does your baby smile when he sees you nearby? ❑ ❑ ❑ ____

6. When in front of a large mirror, does your baby smile or coo at herself?  ❑ ❑ ❑ ____

PERSONAL-SOCIAL TOTAL ____

OVERALL *Parents and providers may use the space below or the back of this 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: _____

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: _____