South Lakes Speech & Language Therapy
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Language Screening – 4 Months

Child's Name: _____ Date of Birth: _____

Person Completing Screening: _____ Date Completed: _____

Directions:
Please highlight or tick each sentence that is true for your baby (e.g. the things he/she IS ABLE TO DO).

1. My baby chuckles softly.

2. After I have been out of sight, my baby stops crying when he/she sees me again.

3. My baby stops crying when he/she hears a voice other than my voice.

4. My baby makes high-pitched squeals.

5. My baby laughs.

6. My baby makes sounds when looking at toys and people.

7. When my baby sees the breast or bottle, he/she knows that he/she is about to feed.

8. My baby watches his/her hands.

9. Before I smile or talk to my baby, he/she smiles when he/she sees me nearby.

10. When in front of a mirror, my baby smiles or coos at him/her self.