South Lakes Speech & Language Therapy
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Language Screening – 6 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 watches my face when I am talking to him/her.

2. My baby turns towards a familiar sound (i.e. rattle).

3. My baby is startled when he/she hears loud noises. Sudden sounds make him/her jump.

4. When my baby is upset, a familiar voice can calm him/her down.

5. My baby seems to know my voice.

6. My baby smiles and laughs in response to my smiles and laughter.

7. My baby makes sounds to himself/herself like cooing, gurgling, and babbling (i.e. ba-ba, ga-ga, da-da).

8. My baby will coo or squeal to get my attention.

9. When I talk to my baby, he/she makes noises in response to me.

10. My baby will look into my eyes and keep eye contact for a long time.