South Lakes Speech & Language Therapy
https://southlakesslt.co.uk
email: SouthLakes.SLT@gmail.com
Tel: 01539 272034

Language Screening – 8 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. If I call my baby when out of sight, he/she looks in direction of my voice.

2. When a loud noise occurs, my baby turns toward the sound source.

3. If I copy my baby's sounds, my baby repeats sounds back to me.

4. My baby makes sounds such as 'da, ga, ka and ba'.

5. My baby responds to tone of voice and stops (briefly) when told 'no'.

6. My baby makes two similar sounds (e.g. 'ga-ga, ba-ba').

7. My baby mouths toys.

8. My baby tries to find dropped toys.

9. My baby plays by banging toys on the floor or on a table.

10. My baby bangs a toy on another toy.

11. My baby passes toys back and forth from one hand to another.

12. My baby reaches out to pat a mirror.