



# 6 Month Questionnaire

(For infants ages 3 through 8 months)

.....

*Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_ .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



# 6 Month ASQ:SE Questionnaire

(For infants ages 3 through 8 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*
2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. When upset, can your baby calm down within a half hour?

☐ z

☐ v

☐ x

☐

2. Does your baby smile at you and other family members?



☐ z

☐ v

☐ x

☐

3. Does your baby like to be picked up and held?

☐ z

☐ v

☐ x

☐

4. Does your baby stiffen and arch her back when picked up?

☐ x

☐ v

☐ z

☐

5. When talking to your baby, does he look at you and seem to be listening?

☐ z

☐ v

☐ x

☐

6. Does your baby let you know when she is hungry or sick?

☐ z

☐ v

☐ x

☐

7. When awake, does your baby seem to enjoy watching or listening to people?

☐ z

☐ v

☐ x

☐

8. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)?



☐ z

☐ v

☐ x

☐

9. Does your baby cry for long periods of time?

☐ x

☐ v

☐ z

☐

10. Is your baby's body relaxed?

☐ z

☐ v

☐ x

☐

TOTAL POINTS ON PAGE —

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
11. Does your baby have trouble sucking from a bottle or breast?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
12. Does it take longer than 30 minutes to feed your baby?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
13. Do you and your baby enjoy mealtimes together (including breast and bottle feeding)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. Does your baby have any eating problems, such as gagging, vomiting, or _____ ? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
15. During the day, does your baby stay awake for an hour or longer at one time?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. Does your baby have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
17. Does your baby sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
18. Does your baby get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>



TOTAL POINTS ON PAGE —

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

19. Has anyone expressed concerns about your baby's behavior? If you checked "sometimes" or "most of the time," please explain:

☒ x

☐ v

☐ z

☐

---

---

---

---

20. Do you have concerns about your baby's eating or sleeping behaviors? If so, please explain:

---

---

---

---

21. Is there anything that worries you about your baby? If so, please explain:

---

---

---

---

22. What things do you enjoy most about your baby?

---

---

---

---

TOTAL POINTS ON PAGE —

# 6 Month ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box = 0 points  
V (for Roman numeral V) next to the checked box = 5 points  
X (for Roman numeral X) next to the checked box = 10 points  
Checked concern = 5 points

Add together:

Total points on page 3 = \_\_\_\_\_  
Total points on page 4 = \_\_\_\_\_  
Total points on page 5 = \_\_\_\_\_  
Child's total score = \_\_\_\_\_

## SCORE INTERPRETATION

1. *Review questionnaires*

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

2. *Transfer child's total score*

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
6 months	45	

3. *Referral criteria*

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

4. *Referral considerations*

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)



# 12 Month/1 Year Questionnaire



(For children ages 9 through 14 months)



## *Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_ .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



# 12 Month/1 Year ASQ:SE Questionnaire

(For children ages 9 through 14 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*

2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your baby laugh or smile at you and other family members?



☐ z

☐ v

☐ x

☐

2. Does your baby look for you when a stranger approaches?

☐ z

☐ v

☐ x

☐

3. Does your baby like to play near and be with family members and friends?

☐ z

☐ v

☐ x

☐

4. Does your baby like to be picked up and held?

☐ z

☐ v

☐ x

☐

5. When upset, can your baby calm down within a half hour?

☐ z

☐ v

☐ x

☐

6. Does your baby stiffen and arch her back when picked up?

☐ x

☐ v

☐ z

☐

7. Does your baby like to play games like Peekaboo?



☐ z

☐ v

☐ x

☐

8. Is your baby's body relaxed?

☐ z

☐ v

☐ x

☐

9. Does your baby cry, scream, or have tantrums for long periods of time?

☐ x

☐ v

☐ z

☐

TOTAL POINTS ON PAGE \_\_\_\_

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

10. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)?



☐ z

☐ v

☐ x

☐

11. Is your baby interested in things around her, such as people, toys, and foods?

☐ z

☐ v

☐ x

☐

12. Does it take longer than 30 minutes to feed your baby?

☐ x

☐ v

☐ z

☐

13. Do you and your baby enjoy mealtimes together?

☐ z

☐ v

☐ x

☐

14. Does your baby have any eating problems, such as gagging, vomiting, or \_\_\_\_\_ ?  
(You may write in another problem.)

☐ x

☐ v

☐ z

☐

15. Does your baby have trouble falling asleep at naptime or at night?

☐ x

☐ v

☐ z

☐

16. Does your baby make babbling sounds? For example, does he put sounds together, like "ba-ba-ba-ba" or "na-na-na-na"? (If your child often babbles, mark "most of the time.")

☐ z

☐ v

☐ x

☐

17. Does your baby sleep at least 10 hours in a 24-hour period?



☐ z

☐ v

☐ x

☐

TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your baby get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
19. Does your baby let you know when she is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. When you talk to your baby, does he turn his head, look, or smile?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your baby try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
22. Has anyone expressed concerns about your baby's behaviors? If you checked "sometimes" or "most of the time," please explain:	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
<hr/> <hr/> <hr/> <hr/>				
23. Do you have concerns about your baby's eating or sleeping behaviors? If so, please explain:	<hr/> <hr/> <hr/> <hr/>			

TOTAL POINTS ON PAGE \_\_\_\_

24. Is there anything that worries you about your baby? If so, please explain:

---

---

---

---

25. What things do you enjoy most about your baby?

---

---

---

---

# 12 Month/1 Year ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Child's total score =	_____

## SCORE INTERPRETATION

### 1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

### 2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
12 months/1 year	48	

### 3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

### 4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?, Have there been any stressful events in the child's life recently?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)



# 18 Month Questionnaire

(For children ages 15 through 20 months)



## *Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_ .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



# 18 Month ASQ:SE Questionnaire

(For children ages 15 through 20 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*
2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your child look at you when you talk to him?

☐ z

☐ v

☐ x

☐

2. When you leave, does your child remain upset and cry for more than an hour?

☐ x

☐ v

☐ z

☐

3. Does your child laugh or smile when you play with her?

☐ z

☐ v

☐ x

☐



4. Does your child look for you when a stranger approaches?

☐ z

☐ v

☐ x

☐

5. Is your child's body relaxed?

☐ z

☐ v

☐ x

☐

6. Does your child like to be hugged or cuddled?

☐ z

☐ v

☐ x

☐

7. When upset, can your child calm down within 15 minutes?

☐ z

☐ v

☐ x

☐

8. Does your child stiffen and arch his back when picked up?

☐ x

☐ v

☐ z

☐

9. Does your child cry, scream, or have tantrums for long periods of time?

☐ x

☐ v

☐ z

☐

TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____. (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
13. Does your child have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. Does your child sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. When you point at something, does your child look in the direction you are pointing?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
17. Does your child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>

TOTAL POINTS ON PAGE \_\_\_\_

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

18. Does your child let you know how she is feeling with gestures or words? For example, does she let you know when she is hungry, hurt, or tired?

☐ z

☐ v

☐ x

☐

19. Does your child follow simple directions? For example, does he sit down when asked?

☐ z

☐ v

☐ x

☐

20. Does your child like to play near or be with family members and friends?

☐ z

☐ v

☐ x

☐

21. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?

☐ z

☐ v

☐ x

☐

22. Does your child like to hear stories or sing songs?


☐ z

☐ v

☐ x

☐

23. Does your child hurt herself on purpose?

☐ x

☐ v

☐ z

☐

24. Does your child like to be around other children?


☐ z

☐ v

☐ x

☐

25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?

☐ x

☐ v

☐ z

☐

TOTAL POINTS ON PAGE —

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

☒ x

☐ v

☐ z

☐

---

---

---

---

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

---

---

---

---

28. Is there anything that worries you about your child? If so, please explain:

---

---

---

---

29. What things do you enjoy most about your child?

---

---

---

---

TOTAL POINTS ON PAGE \_\_\_\_

# 18 Month ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box = 0 points  
V (for Roman numeral V) next to the checked box = 5 points  
X (for Roman numeral X) next to the checked box = 10 points  
Checked concern = 5 points

Add together:

Total points on page 3 = \_\_\_\_\_  
Total points on page 4 = \_\_\_\_\_  
Total points on page 5 = \_\_\_\_\_  
Total points on page 6 = \_\_\_\_\_

Child's total score = \_\_\_\_\_

## CORE INTERPRETATION

### 1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

### 2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
18 months	50	

### 3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

### 4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)



# 24 Month/2 Year Questionnaire



(For children ages 21 through 26 months)



## *Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_ .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



# 24 Month/2 Year ASQ:SE Questionnaire

(For children ages 21 through 26 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*

2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your child look at you when you talk to him?

☐ z

☐ v

☐ x

☐

2. Does your child seem too friendly with strangers?

☐ x

☐ v

☐ z

☐

3. Does your child laugh or smile when you play with her?

☐ z

☐ v

☐ x

☐

4. Is your child's body relaxed?

☐ z

☐ v

☐ x

☐

5. When you leave, does your child remain upset and cry for more than an hour?



☐ x

☐ v

☐ z

☐

6. Does your child greet or say hello to familiar adults?

☐ z

☐ v

☐ x

☐

7. Does your child like to be hugged or cuddled?

☐ z

☐ v

☐ x

☐

8. When upset, can your child calm down within 15 minutes?

☐ z

☐ v

☐ x

☐

9. Does your child stiffen and arch his back when picked up?

☐ x

☐ v

☐ z

☐

TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
11. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
13. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
14. Does your child sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. When you point at something, does your child look in the direction you are pointing?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. Does your child have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
17. Does your child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
18. Does your child follow simple directions? For example, does he sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
TOTAL POINTS ON PAGE ____				

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

19. Does your child let you know how she is feeling with either words or gestures? For example, does she let you know when she is hungry, hurt, or tired?

☐ z

☐ v

☐ x

☐

20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?

☐ z

☐ v

☐ x

☐

21. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or \_\_\_\_\_ .  
(You may write in something else.)

☐ x

☐ v

☐ z

☐

22. Does your child like to hear stories or sing songs?


☐ z

☐ v

☐ x

☐

23. Does your child hurt himself on purpose?

☐ x

☐ v

☐ z

☐

24. Does your child like to be around other children?


☐ z

☐ v

☐ x

☐

25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?

☐ x

☐ v

☐ z

☐

TOTAL POINTS ON PAGE \_\_\_\_

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

☐ x

☐ v

☐ z

☐

---

---

---

---

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

---

---

---

---

28. Is there anything that worries you about your child? If so, please explain:

---

---

---

---

29. What things do you enjoy most about your child?

---

---

---

---

TOTAL POINTS ON PAGE \_\_\_\_

# 24 Month/2 Year ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box = 0 points  
V (for Roman numeral V) next to the checked box = 5 points  
X (for Roman numeral X) next to the checked box = 10 points  
Checked concern = 5 points

Add together:

Total points on page 3 = \_\_\_\_\_  
Total points on page 4 = \_\_\_\_\_  
Total points on page 5 = \_\_\_\_\_  
Total points on page 6 = \_\_\_\_\_

Child's total score = \_\_\_\_\_

## SCORE INTERPRETATION

### 1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

### 2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
24 months/2 years	50	

### 3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

### 4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)



# 30 Month Questionnaire

(For children ages 27 through 32 months)



## *Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_ .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



# 30 Month ASQ:SE Questionnaire

(For children ages 27 through 32 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*
2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your child look at you when you talk to him?

☐ z

☐ v

☐ x

☐

2. Does your child like to be hugged or cuddled?

☐ z

☐ v

☐ x

☐

3. Does your child cling to you more than you expect?



☐ x

☐ v

☐ z

☐

4. Does your child greet or say hello to familiar adults?

☐ z

☐ v

☐ x

☐

5. Does your child seem happy?

☐ z

☐ v

☐ x

☐

6. Does your child like to hear stories and sing songs?

☐ z

☐ v

☐ x

☐

7. Does your child seem too friendly with strangers?

☐ x

☐ v

☐ z

☐

8. Does your child seem more active than other children her age?



☐ x

☐ v

☐ z

☐

9. Can your child settle himself down after periods of exciting activity?

☐ z

☐ v

☐ x

☐

10. Does your child cry, scream, or have tantrums for long periods of time?

☐ x

☐ v

☐ z

☐

11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or \_\_\_\_\_ .  
(You may write in something else.)

☐ x

☐ v

☐ z

☐

TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
12. Can your child stay with activities she enjoys for at least 3 minutes (not including watching television)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
13. Does your child do what you ask him to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. Is your child interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
17. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
18. When you point at something, does your child look in the direction you are pointing?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child let you know how he is feeling with either words or gestures? For example, does he let you know when he is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>



TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
21. Does your child follow routine directions? For example, does she come to the table or help clean up her toys when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
22. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
23. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
24. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
26. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
27. Does your child play alongside other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
28. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>



TOTAL POINTS ON PAGE \_\_\_\_

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

29. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

☒ x

☐ v

☐ z

☐

---

---

---

---

30. Do you have concerns about your child's eating and sleeping behaviors or about her toilet training? If so, please explain:

---

---

---

---

31. Is there anything that worries you about your child? If so, please explain:

---

---

---

---

32. What things do you enjoy most about your child?

---

---

---

---

TOTAL POINTS ON PAGE \_\_\_\_

# 30 Month ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Total points on page 6	= _____

Child's total score = \_\_\_\_\_

## SCORE INTERPRETATION

### 1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

### 2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
30 months	57	

### 3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

### 4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)



# 36 Month/3 Year Questionnaire



(For children ages 33 through 41 months)



*Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_ .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



# 36 Month/3 Year ASQ:SE Questionnaire

(For children ages 33 through 41 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*

2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your child look at you when you talk to her?

☐ z

☐ v

☐ x

☐

2. Does your child like to be hugged or cuddled?



☐ z

☐ v

☐ x

☐

3. Does your child talk and/or play with adults he knows well?

☐ z

☐ v

☐ x

☐

4. Does your child cling to you more than you expect?



☐ x

☐ v

☐ z

☐

5. When upset, can your child calm down within 15 minutes?

☐ z

☐ v

☐ x

☐

6. Does your child seem too friendly with strangers?

☐ x

☐ v

☐ z

☐

7. Can your child settle herself down after periods of exciting activity?

☐ z

☐ v

☐ x

☐

8. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?

☐ z

☐ v

☐ x

☐

9. Does your child seem happy?

☐ z

☐ v

☐ x

☐

TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around him, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
11. Does your child do what you ask her to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
12. Does your child seem more active than other children her age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
13. Can your child stay with activities she enjoys for at least 5 minutes (not including watching television)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
16. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
17. Does your child use words to tell you what he wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
TOTAL POINTS ON PAGE ____				



MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

18. Does your child follow routine directions?  
For example, does she come to the table or  
help clean up her toys when asked?

☐ z

☐ v

☐ x

☐

19. Does your child cry, scream, or have tantrums  
for long periods of time?



☐ x

☐ v

☐ z

☐

20. Does your child check to make sure you are  
near when exploring new places, such as a  
park or a friend's home?



☐ z

☐ v

☐ x

☐

21. Does your child do things over and over  
and can't seem to stop? Examples are  
rocking, hand flapping, spinning,  
or \_\_\_\_\_ .  
(You may write in something else.)

☐ x

☐ v

☐ z

☐

22. Does your child hurt himself on purpose?

☐ x

☐ v

☐ z

☐

23. Does your child stay away from dangerous  
things, such as fire and moving cars?

☐ z

☐ v

☐ x

☐

24. Does your child destroy or damage things on  
purpose?



☐ x

☐ v

☐ z

☐

25. Does your child use words to describe her  
feelings and the feelings of others, such as,  
"I'm happy," "I don't like that," or "She's sad"?

☐ z

☐ v

☐ x

☐

TOTAL POINTS ON PAGE \_\_\_\_

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

26. Can your child name a friend?

☐ z

☐ v

☐ x

☐

27. Do *other* children like to play with your child?

☐ z

☐ v

☐ x

☐

28. Does *your child* like to play with other children?



☐ z

☐ v

☐ x

☐

29. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?

☐ x

☐ v

☐ z

☐

30. Does your child show an interest in or knowledge of adult sexual language and activity?

☐ x

☐ v

☐ z

☐

31. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

☐ x

☐ v

☐ z

☐

---



---



---



---

32. Do you have any concerns about your child's eating, sleeping, or toileting habits? If so, please explain:

---



---



---



---

TOTAL POINTS ON PAGE \_\_\_\_

33. Is there anything that worries you about your child? If so, please explain:

---

---

---

---

34. What things do you enjoy most about your child?

---

---

---

---

# 36 Month/3 Year ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Total points on page 6	= _____
Child's total score =	_____

## SCORE INTERPRETATION

### 1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

### 2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
36 months/3 years	59	

### 3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

### 4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)



# 48 Month/4 Year Questionnaire



(For children ages 42 through 53 months)



## *Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_.
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_.
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



# 48 Month/4 Year ASQ:SE Questionnaire

(For children ages 42 through 53 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

Administering program or provider: \_\_\_\_\_

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*
2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your child look at you when you talk to him?

☐ z

☐ v

☐ x

☐

2. Does your child cling to you more than you expect?

☐ x

☐ v

☐ z

☐



3. Does your child talk and/or play with adults she knows well?

☐ z

☐ v

☐ x

☐

4. When upset, can your child calm down within 15 minutes?

☐ z

☐ v

☐ x

☐

5. Does your child like to be hugged or cuddled?

☐ z

☐ v

☐ x

☐



6. Does your child seem too friendly with strangers?

☐ x

☐ v

☐ z

☐

7. Can your child settle himself down after periods of exciting activity?

☐ z

☐ v

☐ x

☐

8. Does your child cry, scream, or have tantrums for long periods of time?

☐ x

☐ v

☐ z

☐

9. Is your child interested in things around her, such as people, toys, and foods?

☐ z

☐ v

☐ x

☐

TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Does your child stay dry during the day?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
11. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
13. Does your child do what you ask her to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. Does your child seem more active than other children his age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
17. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
18. Can your child stay with activities he enjoys for at least 10 minutes (not including watching television)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
TOTAL POINTS ON PAGE ____				

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
19. Does your child use words to describe her feelings and the feelings of others, such as, "I'm happy," "I don't like that," or "She's sad"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your child explore new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
22. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____. (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
23. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
24. Does your child follow rules (at home, at child care)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
26. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>



TOTAL POINTS ON PAGE \_\_\_\_

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

27. Can your child name a friend?

☐ z

☐ v

☐ x

☐

28. Does your child show concern for other people's feelings? For example, does she look sad when someone is hurt?



☐ z

☐ v

☐ x

☐

29. Do *other* children like to play with your child?

☐ z

☐ v

☐ x

☐

30. Does *your child* like to play with other children?



☐ z

☐ v

☐ x

☐

31. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?

☐ x

☐ v

☐ z

☐

32. Does your child show an interest or knowledge of adult sexual language and activity?

☐ x

☐ v

☐ z

☐

33. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

☐ x

☐ v

☐ z

☐

---



---



---



---

TOTAL POINTS ON PAGE \_\_\_\_

34. Do you have concerns about your child's eating, sleeping, or toileting habits? If so, please explain:

---

---

---

---

35. Is there anything that worries you about your child? If so, please explain:

---

---

---

---

36. What things do you enjoy most about your child?

---

---

---

---

# 48 Month/4 Year ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box = 0 points  
V (for Roman numeral V) next to the checked box = 5 points  
X (for Roman numeral X) next to the checked box = 10 points  
Checked concern = 5 points

Add together:

Total points on page 3 = \_\_\_\_\_  
Total points on page 4 = \_\_\_\_\_  
Total points on page 5 = \_\_\_\_\_  
Total points on page 6 = \_\_\_\_\_

Child's total score = \_\_\_\_\_

## SCORE INTERPRETATION

### 1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

### 2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
48 months/4 years	70	

### 3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

### 4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)



# 60 Month/5 Year Questionnaire

(For children ages 54 through 65 months)

.....

## *Important Points to Remember:*

- ☒ Please return this questionnaire by \_\_\_\_\_ .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- ☒ Thank you for your participation in this project.



# 60 Month/5 Year ASQ:SE Questionnaire

(For children ages 54 through 65 months)

.....

Please provide the following information.

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

What is your relationship to the child? \_\_\_\_\_

Your telephone: \_\_\_\_\_

Your mailing address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

List people assisting in questionnaire completion: \_\_\_\_\_

\_\_\_\_\_

Administering program or provider: \_\_\_\_\_

**ASQ:SE™**

Please read each question carefully and

1. Check the box ☐ that best describes your child's behavior *and*
2. Check the circle ☐ if this behavior is a concern

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

1. Does your child look at you when you talk to her?

☐ z

☐ v

☐ x

☐

2. Does your child cling to you more than you expect?

☐ x

☐ v

☐ z

☐

3. Does your child like to be hugged or cuddled?



☐ z

☐ v

☐ x

☐

4. Does your child talk and/or play with adults he knows well?

☐ z

☐ v

☐ x

☐

5. When upset, can your child calm down within 15 minutes?

☐ z

☐ v

☐ x

☐

6. Does your child seem too friendly with strangers?

☐ x

☐ v

☐ z

☐

7. Can your child settle herself down after periods of exciting activity?

☐ z

☐ v

☐ x

☐

8. Does your child seem happy?

☐ z

☐ v

☐ x

☐

9. Does your child cry, scream, or have tantrums for long periods of time?



☐ x

☐ v

☐ z

☐

TOTAL POINTS ON PAGE —

		MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around him, such as people, toys, and foods?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
11. Does your child go to the bathroom by herself? (Reminders and help with wiping are okay.)		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)		<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
13. Can your child stay with activities he enjoys for at least 15 minutes (not including watching television)?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. Do you and your child enjoy mealtimes together?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. Does your child do what you ask her to do?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. Does your child seem more active than other children his age?		<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
17. Does your child sleep at least 8 hours in a 24-hour period?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>

TOTAL POINTS ON PAGE \_\_\_\_

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. Does your child use words to describe his feelings and the feelings of others, such as, "I'm happy," "I don't like that," or "She's sad"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your child explore new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
22. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
24. Does your child follow rules (at home, at child care)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>



TOTAL POINTS ON PAGE \_\_\_\_

MOST  
OF THE  
TIME

SOMETIMES

RARELY  
OR  
NEVER

CHECK IF  
THIS IS A  
CONCERN

26. Does your child stay away from dangerous things, such as fire and moving cars?

☐ z

☐ v

☐ x

☐

27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?

☐ z

☐ v

☐ x

☐

28. Do *other* children like to play with your child?



☐ z

☐ v

☐ x

☐

29. Does *your child* like to play with other children?

☐ z

☐ v

☐ x

☐

30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?

☐ x

☐ v

☐ z

☐

31. Does your child take turns and share when playing with other children?

☐ z

☐ v

☐ x

☐

32. Does your child show an interest or knowledge of adult sexual language and activity?

☐ x

☐ v

☐ z

☐

33. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

☐ x

☐ v

☐ z

☐

---



---



---



---

TOTAL POINTS ON PAGE \_\_\_\_

34. Do you have concerns about your child's eating, sleeping, or toileting habits? If so, please explain:

---

---

---

---

35. Is there anything that worries you about your child? If so, please explain:

---

---

---

---

36. What things do you enjoy most about your child?

---

---

---

---

# 60 Month/5 Year ASQ:SE Information Summary

Child's name: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_  
Person filling out the ASQ:SE: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Assisting in ASQ:SE completion: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Administering program/provider: \_\_\_\_\_

## SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box = 0 points  
V (for Roman numeral V) next to the checked box = 5 points  
X (for Roman numeral X) next to the checked box = 10 points  
Checked concern = 5 points

Add together:

Total points on page 3 = \_\_\_\_\_  
Total points on page 4 = \_\_\_\_\_  
Total points on page 5 = \_\_\_\_\_  
Total points on page 6 = \_\_\_\_\_

Child's total score = \_\_\_\_\_

## CORE INTERPRETATION

### 1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

### 2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
60 months/5 years	70	

### 3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

### 4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors  
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors  
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors  
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors  
(e.g., Is the child's behavior acceptable given cultural or family context?)