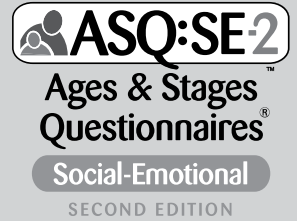




30 Month Questionnaire

27 months 0 days through 32 months 30 days



Date ASQ:SE-2 completed: _____

Child's information

Child's first name: _____ Child's middle initial: _____ Child's last name: _____

Child's date of birth: _____

Child's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

City: _____ State/province: _____ ZIP/postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Relationship to child: Parent Guardian Teacher Other: _____
 Grandparent/other relative Foster parent Child care provider

People assisting in questionnaire completion: _____

Program information

(For program use only.)

Child's ID #:	Age at administration in months and days:
Program ID #:	
Program name:	

30 Month Questionnaire 27 months 0 days through 32 months 30 days



Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.

Important Points to Remember:

- Answer questions based on what you know about your child's behavior.
- Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- Caregivers who know the child well and spend more than 15-20 hours per week with the child should complete ASQ:SE-2.
- Please return this questionnaire by: _____
- If you have any questions or concerns about your child or about this questionnaire, contact: _____
- Thank you and please look forward to filling out another ASQ:SE-2 in _____ months.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to him?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
3. Does your child cling to you more than you expect?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
4. Does your child greet or say hello to familiar adults?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. Does your child like to hear stories and sing songs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
7. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____





TOTAL POINTS ON PAGE _____

30 Month Questionnaire



Check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
<p>8. Does your child settle herself down after exciting activities?</p> 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
<p>9. Does your child cry, scream, or have tantrums for long periods of time?</p>	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
<p>10. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or _____? (Please describe.)</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
<p>11. Does your child stay with activities she enjoys for at least 3 minutes (other than watching shows or videos, or playing with electronics)?</p>	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
<p>12. Does your child do what you ask him to do?</p>	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
<p>13. Is your child interested in things around her, such as people, toys, and foods?</p> 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
<p>14. When upset, can your child calm down within 15 minutes?</p>	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
<p>15. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.)</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

30 Month Questionnaire



Check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.


	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
16. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
17. 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"/> v	_____
18. 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"/> v	_____
19. Does your child let you know how she is feeling with words or gestures? For example, does she 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"/> v	_____
20. Does your child follow routine directions? For example, does he come to the table or help clean up his toys when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
21. 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"/> v	_____
22. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
23. 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"/> v	_____
24. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
25. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

30 Month Questionnaire



Check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
26. Does your child play next to other children? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
27. 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"/> v	_____
28. Does your child try to show you things by pointing at them and looking back at you?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
29. Does your child use at least two words to ask for things he wants? For example, does he say "want ball" or "more apple?"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
30. Does your child play with objects by pretending? For example, does your child pretend to talk on the phone, feed a doll, or fly a toy airplane?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
31. Does your child wake three or more times during the night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
32. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
33. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

OVERALL Use the space below for additional comments.

34. Do you have concerns about your child's eating and sleeping behaviors or about her toilet training?

If yes, please explain:

YES NO

35. Does anything about your child worry you? If yes, please explain:

YES NO

36. What do you enjoy about your child?

30 Month Information Summary 27 months 0 days through 32 months 30 days



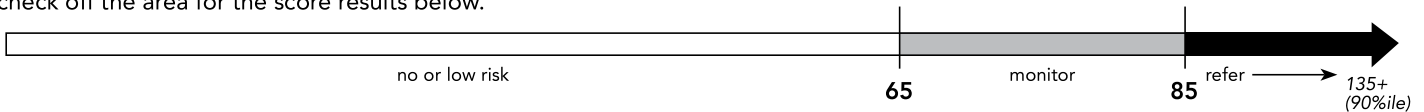
Child's name: _____ Date ASQ:SE-2 completed: _____
 Child's ID #: _____ Child's date of birth: _____
 Person who completed ASQ:SE-2: _____ Child's age in months and days: _____
 Administering program/provider: _____ Child's gender: Male Female

1. ASQ:SE-2 SCORING CHART:

- Score items (Z = 0, V = 5, X = 10, Concern = 5).
- Transfer the page totals and add them for the total score.
- Record the child's total score next to the cutoff.

TOTAL POINTS ON PAGE 1		Cutoff	TOTAL SCORE
TOTAL POINTS ON PAGE 2			
TOTAL POINTS ON PAGE 3			
TOTAL POINTS ON PAGE 4			
Total score		85	

2. ASQ:SE-2 SCORE INTERPRETATION: Review the approximate location of the child's total score on the scoring graphic. Then, check off the area for the score results below.



- ___ The child's total score is in the area. It is below the cutoff. Social-emotional development appears to be on schedule.
 ___ The child's total score is in the area. It is close to the cutoff. Review behaviors of concern and monitor.
 ___ The child's total score is in the area. It is above the cutoff. Further assessment with a professional may be needed.

3. OVERALL RESPONSES AND CONCERNS: Record responses and transfer parent/caregiver comments. YES responses require follow-up.

- 1-33. Any Concerns marked on scored items? **YES** no Comments: _____
34. Eating/sleeping/toileting concerns? **YES** no Comments: _____
35. Other worries? **YES** no Comments: _____

4. FOLLOW-UP REFERRAL CONSIDERATIONS: Mark all as Yes, No, or Unsure (Y, N, U). See pages 98-103 in the ASQ:SE-2 User's Guide.

- ___ **Setting/time factors** (e.g., Is the child's behavior the same at home as at school?)
 ___ **Developmental factors** (e.g., Is the child's behavior related to a developmental stage or 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 the child's cultural or family context? Have there been any stressful events in the child's life recently?)
 ___ **Parent concerns** (e.g., Did the parent/caregiver express any concerns about the child's behavior?)

5. FOLLOW-UP ACTION: Check all that apply.

- ___ Provide activities and rescreen in _____ months.
 ___ Share results with primary health care provider.
 ___ Provide parent education materials.
 ___ Provide information about available parenting classes or support groups.
 ___ Have another caregiver complete ASQ:SE-2. List caregiver here (e.g., grandparent, teacher): _____
 ___ Administer developmental screening (e.g., ASQ-3).
 ___ Refer to early intervention/early childhood special education.
 ___ Refer for social-emotional, behavioral, or mental health evaluation.
 ___ Other: _____