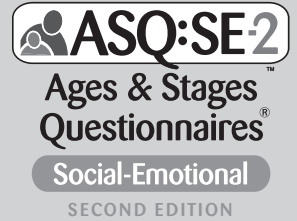




# 24 Month Questionnaire

21 months 0 days through 26 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: \_\_\_\_\_

# 24 Month QUESTIONNAIRE 21 months 0 days through 26 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 seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
3. Does your child laugh or smile when you play with her?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. Is your child's body relaxed?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. When you leave, does your child stay upset and cry for more than an hour?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
6. 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	_____
7. 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	_____
8. 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"/> v	_____

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

# 24 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	
9. Does your child stiffen and arch his back when picked up?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
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"/> v	_____
					
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"/> v	_____
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
13. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
_____					
_____					
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"/> v	_____
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"/> v	_____
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"/> v	_____
17. Does your child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

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

# 24 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	
18. Does your child follow simple directions? For example, does she sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
19. Does your child let you know how he is feeling with 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"/> v	_____
20. 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	_____
21. Does your child do things over and over and get upset when you try to stop her? For example, does she rock, flap her hands, spin, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
22. Does your child like to hear stories or sing songs? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
23. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
24. Does your child like to be around other children? For example, does she move close to or look at other children? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
25. 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	_____
26. 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	_____

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

# 24 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	
27. 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	_____
28. 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	_____
29. Does your child respond to his name when you call him? For example, does he turn his head and look at you?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
30. 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	_____
31. 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.

32. Do you have concerns about your child's eating or sleeping behaviors? If yes, please explain:  YES  NO

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33. Does anything about your child worry you? If yes, please explain:  YES  NO

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34. What do you enjoy about your child?

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# 24 Month Information Summary 21 months 0 days through 26 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

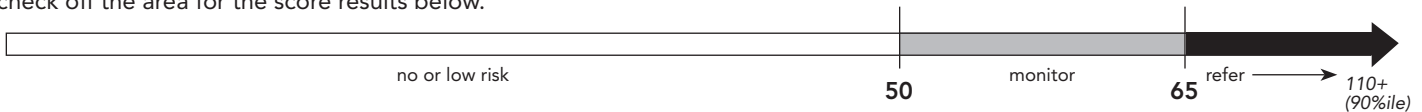
## 1. ASQ:SE-2 SCORING CHART:

- 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	
TOTAL POINTS ON PAGE 2	
TOTAL POINTS ON PAGE 3	
TOTAL POINTS ON PAGE 4	
<b>Total score</b>	

Cutoff	Total score
<b>65</b>	

## 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.

- 1-31. Any Concerns marked on scored items?    **YES**    no    Comments: \_\_\_\_\_
32. Eating/sleeping concerns?    **YES**    no    Comments: \_\_\_\_\_
33. 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: \_\_\_\_\_