

Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghhee Kim**
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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.



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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: _____

ASQ[®] SETM

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 ____

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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.



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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: _____

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 baby laugh or smile at you and other family members?

 z v x o

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

 z v x o

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

 z v x o

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

 z v x o

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

 z v x o

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

 x v z o

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

 z v x o

8. Is your baby's body relaxed?

 z v x o

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

 x v z o

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)?		<input type="checkbox"/> z <input type="checkbox"/> v <input checked="" type="checkbox"/> x	<input type="radio"/>	
11. Is your baby interested in things around her, such as people, toys, and foods?		<input type="checkbox"/> z <input type="checkbox"/> v <input checked="" type="checkbox"/> x	<input type="radio"/>	
12. Does it take longer than 30 minutes to feed your baby?		<input checked="" type="checkbox"/> x <input type="checkbox"/> v <input type="checkbox"/> z	<input type="radio"/>	
13. Do you and your baby enjoy mealtimes together?		<input type="checkbox"/> z <input type="checkbox"/> v <input checked="" 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 checked="" type="checkbox"/> x <input type="checkbox"/> v <input type="checkbox"/> z	<input type="radio"/>	
15. 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"/>	
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.”)		<input type="checkbox"/> z <input type="checkbox"/> v <input checked="" type="checkbox"/> x	<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 checked="" 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 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:	<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?

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18 Month Questionnaire

(For children ages 15 through 20 months)

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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.



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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: _____

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 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?

z v x

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

12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____?
(You may write in another problem.)

x v z

13. Does your child have trouble falling asleep at naptime or at night?

x v z

14. Do you and your child enjoy mealtimes together?

z v x

15. Does your child sleep at least 10 hours in a 24-hour period?

z v x

16. When you point at something, does your child look in the direction you are pointing?

z v x

17. Does your child get constipated or have diarrhea?

x v z

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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>	
19. 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 checked="" type="radio"/>	
20. Does your child like to play near or be with family members and friends?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>	
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 checked="" type="radio"/>	
22. Does your child like to hear stories or sing songs?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>
23. Does your child hurt herself on purpose?		<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" type="radio"/>
24. Does your child like to be around other children?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>
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 checked="" type="radio"/>

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:	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
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?	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

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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.



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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: _____

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 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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>	
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 checked="" type="radio"/>	
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.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" type="radio"/>	
22. Does your child like to hear stories or sing songs?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>
23. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" type="radio"/>	
24. Does your child like to be around other children?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>
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 checked="" type="radio"/>	

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 ____

**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System
Second Edition**

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

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24 Month • 2 Year **Questionnaire**



On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Be sure to try each activity with your child before checking a box.
- Try to make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested, fed, and ready to play.
- Please return this questionnaire by _____.
- If you have any questions or concerns about your child or about this questionnaire, please call: _____.
- Look forward to filling out another questionnaire in _____ months.



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24 Month • 2 Year **Questionnaire**

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: _____



At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, score "yes" for the item.

YES SOMETIMES NOT YET

COMMUNICATION

Be sure to try each activity with your child.

1. Without showing her first, does your child *point* to the correct picture when you say, "Show me the kitty" or ask, "Where is the dog?" (She needs to identify only one picture correctly.) _____
2. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Check "yes" even if his words are difficult to understand.) _____
3. Without giving her clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions? _____
 - a. "Put the toy on the table."
 - b. "Close the door."
 - c. "Bring me a towel."
 - d. "Find your coat."
 - e. "Take my hand."
 - f. "Get your book."
4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture? _____
5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "Bye-bye," "All gone," "All right," and "What's that?") _____

Please give an example of your child's word combinations:

6. Does your child correctly use at least two words like "me," "I," "mine," and "you"? _____

COMMUNICATION TOTAL _____

GROSS MOTOR

Be sure to try each activity with your child.

1. Does your child walk down stairs if you hold onto one of his hands? (You can look for this at a store, on a playground, or at home.) _____
2. When you show her how to kick a large ball, does your child try to kick the ball by moving her leg forward or by walking into it? (If your child already kicks a ball, check "yes" for this item.)  _____
3. Does your child walk either up or down at least two steps by himself? You can look for this at a store, on a playground, or at home. (Check "yes" even if he holds onto the wall or railing.)  _____
4. Does your child run fairly well, stopping herself without bumping into things or falling?  _____

YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

5. Does your child jump with both feet leaving the floor at the same time?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

GROSS MOTOR TOTAL —

*If gross motor item 6 is marked "yes" or "sometimes," mark gross motor item 2 as "yes."

FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

2. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

3. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

4. Does your child flip switches off and on?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

5. Does your child stack seven small blocks or toys on top of each other by himself? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

6. Does your child thread a shoelace through either a bead or an eyelet of a shoe?



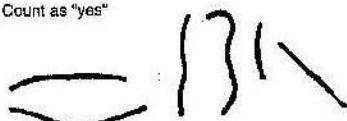
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
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FINE MOTOR TOTAL —

PROBLEM SOLVING

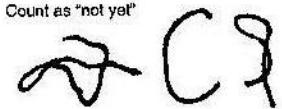
Be sure to try each activity with your child.

Count as "yes"



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

Count as "not yet"



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

2. Without showing him how, does your child purposefully turn a small, clear bottle upside down to dump out a crumb or Cheerio? (You can use a soda-pop bottle or baby bottle.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
--------------------------	--------------------------	--------------------------	--------------------------	---

YES SOMETIMES NOT YET

PROBLEM SOLVING

(continued)

3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it?
6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? (You can also use spools of thread, small boxes, or other toys.) 

PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

Be sure to try each activity with your child.

1. Does your child drink from a cup or glass, putting it down again with little spilling?
2. Does your child copy activities you do, such as wipe up a spill, sweep, shave, or comb hair?
3. Does your child eat with a fork?
4. When playing with either a stuffed animal or doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?
5. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if he cannot turn?
6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."

PERSONAL-SOCIAL TOTAL

OVERALL

Parents and providers may use the space at the bottom of the next sheet for additional comments.

1. Do you think your child hears well?

YES NO

If no, explain: _____

2. Do you think your child talks like other toddlers her age?

YES NO

If no, explain: _____



24 Month/2 Year ASQ Information Summary

Child's name: _____

Date of birth: _____

Person filling out the ASQ: _____

Relationship to child: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____

Assisting in ASQ completion: _____

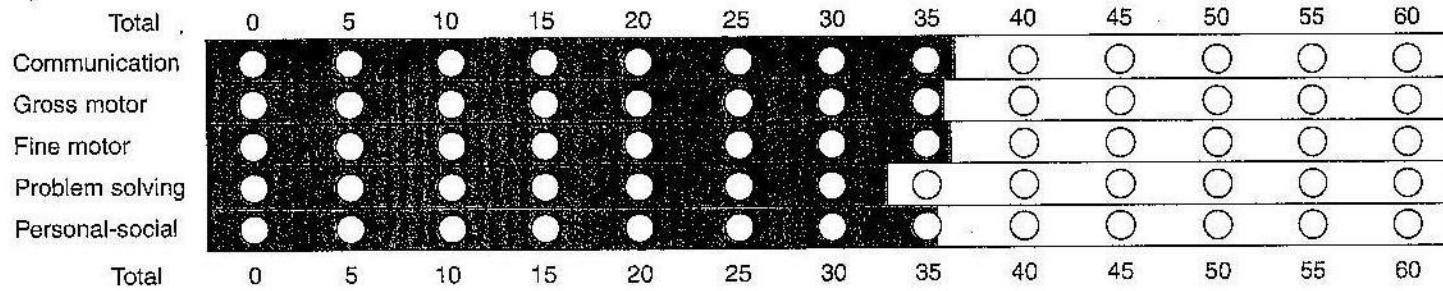
Today's date: _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

- | | | | |
|--|-------------|---|-------------|
| 1. Hears well?
Comments: | YES NO | 5. Family history of hearing impairment?
Comments: | YES NO |
| 2. Talks like other toddlers?
Comments: | YES NO | 6. Vision okay?
Comments: | YES NO |
| 3. Understand child?
Comments: | YES NO | 7. Recent medical problems?
Comments: | YES NO |
| 4. Walks, runs, and climbs like others?
Comments: | YES NO | 8. Other concerns?
Comments: | YES NO |
-

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide*.
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

24 months/2 years	Score Cutoff	Communication			Gross motor			Fine motor			Problem solving			Personal-social		
		1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Communication	36.5	<input type="checkbox"/>														
Gross motor	36.0	<input type="checkbox"/>														
Fine motor	36.4	<input type="checkbox"/>														
Problem solving	32.9	<input type="checkbox"/>														
Personal-social	35.6	<input type="checkbox"/>														
		Y	S	N	Y	S	N	Y	S	N	Y	S	N	Y	S	N

Administering program or provider: _____

Ages & Stages Questionnaires: Social-Emotional
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By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghhee Kim**
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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.



Ages & Stages Questionnaires: Social-Emotional
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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: _____

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 him? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input checked="" type="radio"/> | |
| 2. Does your child like to be hugged or cuddled? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input checked="" type="radio"/> | |
| 3. Does your child cling to you more than you expect? |  | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input checked="" type="radio"/> |
| 4. Does your child greet or say hello to familiar adults? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input checked="" type="radio"/> | |
| 5. Does your child seem happy? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input checked="" type="radio"/> | |
| 6. Does your child like to hear stories and sing songs? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input checked="" type="radio"/> | |
| 7. Does your child seem too friendly with strangers? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input checked="" type="radio"/> | |
| 8. Does your child seem more active than other children her age? |  | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input checked="" type="radio"/> |
| 9. Can your child settle himself down after periods of exciting activity? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input checked="" type="radio"/> | |
| 10. 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 checked="" 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 checked="" type="radio"/> | |

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 checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" type="radio"/>	
17. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" type="radio"/>
26. Does your child hurt himself on purpose?		<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" type="radio"/>
27. Does your child play alongside other children?		<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" 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 checked="" 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: _____

Telephone: _____

City: _____ State: _____ ZIP: _____

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?)

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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.



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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: _____

ASQ[®] SETM

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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>
19. 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 checked="" type="radio"/>
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 checked="" type="radio"/>
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.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" type="radio"/>
22. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" type="radio"/>
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 checked="" type="radio"/>
24. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" type="radio"/>
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"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input checked="" type="radio"/>

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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
27. Do <i>other</i> children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
28. Does <i>your child</i> like to play with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
29. 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"/>
30. Does your child show an interest in or knowledge of sexual language and activity?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
31. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	<hr/> <hr/> <hr/>			<input type="radio"/>
32. Do you have any concerns about your child's eating, sleeping, or toileting habits? If so, please explain:	<hr/> <hr/> <hr/>			

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?

**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System
Second Edition**

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

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36 Month • 3 Year **Questionnaire**



On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Be sure to try each activity with your child before checking a box.
- Try to make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested, fed, and ready to play.
- Please return this questionnaire by _____.
- If you have any questions or concerns about your child or about this questionnaire, please call: _____.
- Look forward to filling out another questionnaire in _____ months.



**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System
Second Edition**

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

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36 Month • 3 Year **Questionnaire**

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: _____



YES SOMETIMES NOT YET

COMMUNICATION *Be sure to try each activity with your child.*

1. When you ask her to point to her nose, eyes, hair, feet, ears, and so forth, does your child correctly point to at least seven body parts? (She can point to parts of herself, you, or a doll.) —
2. Does your child make sentences that are three or four words long? —

Please give an example:

3. Without giving him help by pointing or using gestures, ask your child to "Put the shoe *on* the table" and "Put the book *under* the chair." Does your child carry out both of these directions correctly? —
4. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture? (For example, "Barking," "Running," "Eating," and "Crying") You may ask, "What is the dog (or boy) doing?" —
5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle and ask your child to move the zipper *down*. Return the zipper to the middle and ask your child to move the zipper *up*. Do this several times, placing the zipper in the middle before asking your child to move it up or down. Does your child consistently move the zipper up when you say "up" and down when you say "down"? —
6. When you ask, "What is your name?" does your child say both her first and last names? —

COMMUNICATION TOTAL —

GROSS MOTOR *Be sure to try each activity with your child.*

1. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?



 —

2. Does your child jump with both feet leaving the floor at the same time?



 —

3. Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) She may hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)



 —

YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

4. Does your child stand on one foot for about 1 second without holding onto anything?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

5. While standing, does your child throw a ball *overhand* by raising his arm to shoulder height and throwing the ball forward? (Dropping the ball or throwing the ball underhand does not count.)



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

GROSS MOTOR TOTAL _____

FINE MOTOR *Be sure to try each activity with your child.*

Count as "yes"

1. After she watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask your child to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Count as "not yet"



2. Does your child thread a shoelace through either a bead or an eyelet of a shoe?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

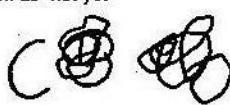
Count as "yes"

3. After he watches you draw a single circle, ask your child to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Count as "not yet"



4. After she watches you draw a line from one side of the paper to the other side, ask your child to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Count as "yes"

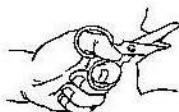


<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

YES SOMETIMES NOT YET

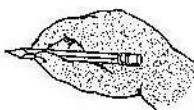
FINE MOTOR *(continued)*

5. Does your child try to cut paper with child-safe scissors? He does not need to cut the paper but must get the blades to open and close while holding the paper with the other hand. (You may show your child how to use scissors. Carefully watch your child's use of scissors for safety reasons.)



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------

6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?

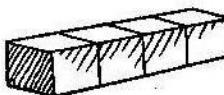


<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------

FINE MOTOR TOTAL

PROBLEM SOLVING *Be sure to try each activity with your child.*

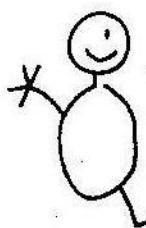
1. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up four objects in a row? (You can also use spools of thread, small boxes, or other toys.)



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------

2. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------

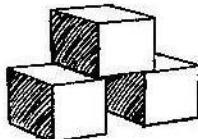
3. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person? Responses like "snowman," "boy," "man," "girl," and "Daddy" are correct.

Please write your child's response here:

4. When you say, "Say seven three," does your child repeat just the two numbers in the correct order? *Do not repeat the numbers.* If necessary, try another pair of numbers and say, "Say eight two." Your child must repeat just one series of two numbers for you to answer "yes" to this question.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------

5. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it?



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------

6. When you say, "Say five eight three," does your child repeat just the three numbers in the correct order? *Do not repeat these numbers.* If necessary, try another series of numbers and say, "Say six nine two." Your child must repeat just one series of three numbers for you to answer "yes" to this question.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
--------------------------	--------------------------	--------------------------	--------------------------	-------

PROBLEM SOLVING TOTAL

YES SOMETIMES NOT YET

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. Does your child use a spoon to feed herself with little spilling?
2. Does your child push a little shopping cart, stroller, or wagon, steering it around objects and backing out of corners if he cannot turn?
3. When she is looking in a mirror and you ask, "Who is in the mirror?" does your child say either "Me" or her own name?
4. Can your child put on a coat, jacket, or shirt by himself?
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?
6. Does your child take turns by waiting while another child or adult takes a turn?

PERSONAL-SOCIAL TOTAL

OVERALL *Parents and providers may use the space below or the back of this sheet for additional comments.*

1. Do you think your child hears well? YES NO
If no, explain: _____
2. Do you think your child talks like other children her age? YES NO
If no, explain: _____
3. Can you understand most of what your child says? YES NO
If no, explain: _____
4. Do you think your child walks, runs, and climbs like other children his age? YES NO
If no, explain: _____
5. Does either parent have a family history of childhood deafness or hearing impairment? YES NO
If yes, explain: _____
6. Do you have any concerns about your child's vision? YES NO
If yes, explain: _____
7. Has your child had any medical problems in the last several months? YES NO
If yes, explain: _____
8. Does anything about your child worry you? YES NO
If yes, explain: _____

36 Month/3 Year ASQ Information Summary

Child's name: _____

Date of birth: _____

Person filling out the ASQ: _____

Relationship to child: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____

Assisting in ASQ completion: _____

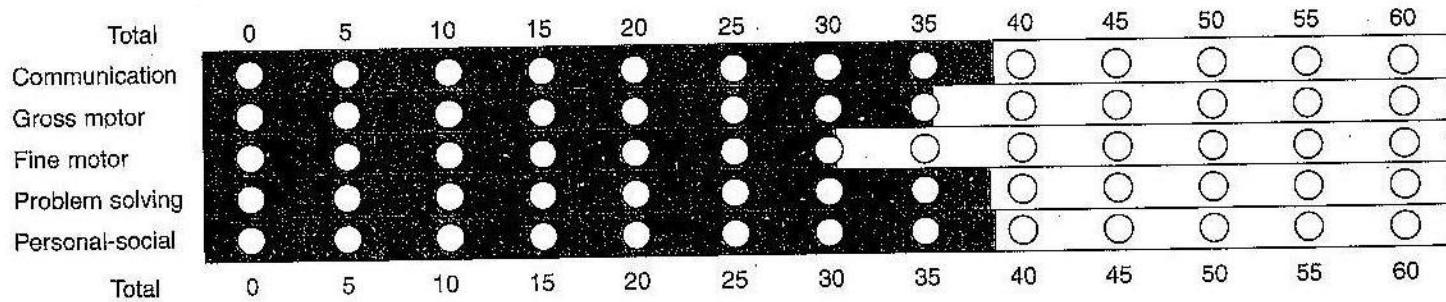
Today's date: _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1. Hears well? Comments:	YES	NO	5. Family history of hearing impairment? Comments:	YES	NO
2. Talks like other children? Comments:	YES	NO	6. Vision okay? Comments:	YES	NO
3. Understand child? Comments:	YES	NO	7. Recent medical problems? Comments:	YES	NO
4. Walks, runs, and climbs like others? Comments:	YES	NO	8. Other concerns? Comments:	YES	NO

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide*.
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

36 months/3 years	Score	Cutoff	Communication			Gross motor			Fine motor			Problem solving			Personal-social		
			1	2	3	4	5	6	1	2	3	4	5	6	1	2	3
Communication		38.7	<input type="radio"/>														
Gross motor		35.7	<input type="radio"/>														
Fine motor		30.7	<input type="radio"/>														
Problem solving		38.6	<input type="radio"/>														
Personal-social		38.7	<input type="radio"/>														
			Y	S	N	Y	S	N	Y	S	N	Y	S	N	Y	S	N

Administering program or provider: _____

Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghhee Kim**
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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.



Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By Jane Squires, Diane Bricker, & Elizabeth Twombly
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghhee Kim
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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: _____

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 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 checked="" 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 checked="" 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 checked="" 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 checked="" type="radio"/>	
23. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input checked="" 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 checked="" 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 checked="" 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 checked="" type="radio"/>	

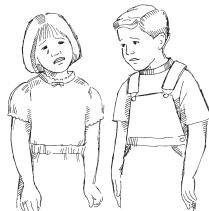
TOTAL POINTS ON PAGE ____

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 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?

**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System
Second Edition**

By Diane Bricker and Jane Squires

with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

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48 Month • 4 Year Questionnaire



On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Be sure to try each activity with your child before checking a box.
- Try to make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested, fed, and ready to play.
- Please return this questionnaire by _____.
- If you have any questions or concerns about your child or about this questionnaire, please call: _____.
- Look forward to filling out another questionnaire in _____ months.



**Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System
Second Edition**

By Diane Bricker and Jane Squires

with assistance from **Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell**

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48 Month • 4 Year **Questionnaire**

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: _____



YES SOMETIMES NOT YET

COMMUNICATION

Be sure to try each activity with your child.

1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like, "Cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like, "Cow, dog, and elephant?"

2. Does your child answer the following questions:

"What do you do when you are hungry?" (Acceptable answers include: "Get food," "Eat," "Ask for something to eat," and "Have a snack.")

Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include: "Take a nap," "Rest," "Go to sleep," "Go to bed," "Lie down," and "Sit down.")

Please write your child's response:

Mark "sometimes" if your child answers only one question.

3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does he say something like, "It's round. I throw it. It's big"?

4. Does your child use endings of words, such as "s," "ed," and "ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?

5. Without giving help by pointing or repeating, does your child follow three directions that are unrelated to one another? For example, you may ask your child to "Clap your hands, walk to the door, and sit down."

6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I am going to the park," or "Is there a toy to play with?" or "Are you coming, too?"

COMMUNICATION TOTAL

GROSS MOTOR

Be sure to try each activity with your child.



1. Does your child catch a large ball with both hands? You should stand about 5 feet away and give your child two or three tries.

2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?

3. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise her arm to shoulder height and throw the ball forward. (Dropping the ball, letting the ball go, or throwing the ball underhand should be scored as "not yet.")



YES SOMETIMES NOT YET

GROSS MOTOR *(continued)*

4. Does your child hop up and down on either the right or left foot at least one time without losing his balance or falling?
5. Does your child jump forward a distance of 20 inches from a standing position, starting with her feet together?
6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing his balance and putting his foot down? You may give your child two or three tries before you mark the question. 

GROSS MOTOR TOTAL

FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child put together a six-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)
2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.) 
3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil or crayon, without tracing? Your child's drawings should look similar to the design of the shapes below, but they may be different in size.



4. Does your child unbutton one or more buttons? Your child may use his own clothing or a doll's clothing.
5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?
6. Does your child color mostly within the lines in a coloring book? Your child should not go more than $\frac{1}{4}$ inch outside the lines on most of the picture.

FINE MOTOR TOTAL

YES SOMETIMES NOT YET

PROBLEM SOLVING *Be sure to try each activity with your child.*

1. When you say, "Say five eight three," does your child repeat *just* these three numbers in the correct order? *Do not repeat these numbers.* If necessary, try another series of numbers and say, "Say six nine two." Your child must repeat just one series of three numbers to answer "yes" to this question.

 —

2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? Ask this question *without* providing help by pointing, gesturing, or looking at the smallest circle.



 —

3. Without giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put a book "*under* the couch." Then ask her to put the ball "*between* the chairs" and the shoe "*in the middle* of the table."

 —

4. When shown an object and asked, "What color is this?" does your child name five different colors like red, blue, yellow, orange, black, white, or pink? Answer "yes" only if your child answers the question correctly using five colors.

 —

5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother or sister, or an imaginary animal or figure.

 —

6. If you place five objects in front of your child, can he count them saying, "One, two, three, four, five," in order? Ask this question *without* providing help by pointing, gesturing, or naming.

 —

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. Does your child serve herself, taking food from one container to another using utensils? For example, can your child use a large spoon to scoop applesauce from a jar into a bowl?

 —

2. Does your child tell you at least four of the following:

- | | |
|----------------------|---------------------|
| a. First name | d. Last name |
| b. Age | e. Boy or girl |
| c. City she lives in | f. Telephone number |

Please circle the items your child knows.

 —

3. Does your child wash his hands and face using soap and dry off with a towel without help?

 —

4. Does your child tell you the names of two or more playmates, not including brothers and sisters? Ask this question without providing help by suggesting names of playmates or friends.

 —

YES SOMETIMES NOT YET

PERSONAL-SOCIAL (*continued*)

5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all her teeth without help? You may still need to check and rebrush your child's teeth.

6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)?

PERSONAL-SOCIAL TOTAL _____

OVERALL

Parents and providers may use the space below or the back of this sheet for additional comments.

1. Do you think your child hears well?

YES NO

If no, explain: _____

2. Do you think your child talks like other children her age?

YES NO

If no, explain: _____

3. Can you understand most of what your child says?

YES NO

If no, explain: _____

4. Do you think your child walks, runs, and climbs like other children his age?

YES NO

If no, explain: _____

5. Does either parent have a family history of childhood deafness or hearing impairment?

YES NO

If yes, explain: _____

6. Do you have any concerns about your child's vision?

YES NO

If yes, explain: _____

7. Has your child had any medical problems in the last several months?

YES NO

If yes, explain: _____

8. Does anything about your child worry you?

YES NO

If yes, explain: _____

48 Month/4 Year ASQ Information Summary

Child's name: _____ Date of birth: _____
 Person filling out the ASQ: _____ Relationship to child: _____
 Mailing address: _____ City: _____ State: _____ ZIP: _____
 Telephone: _____ Assisting in ASQ completion: _____
 Today's date: _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

- | | | | |
|--|-------------|---|-------------|
| 1. Hears well?
Comments: | YES NO | 5. Family history of hearing impairment?
Comments: | YES NO |
| 2. Talks like other children?
Comments: | YES NO | 6. Vision okay?
Comments: | YES NO |
| 3. Understand child?
Comments: | YES NO | 7. Recent medical problems?
Comments: | YES NO |
| 4. Walks, runs, and climbs like others?
Comments: | YES NO | 8. Other concerns?
Comments: | YES NO |

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide*.
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.

Total	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	<input type="radio"/>												
Gross motor	<input type="radio"/>												
Fine motor	<input type="radio"/>												
Problem solving	<input type="radio"/>												
Personal-social	<input type="radio"/>												
Total	0	5	10	15	20	25	30	35	40	45	50	55	60

Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

48 months/4 years	Score	Cutoff	Communication			Gross motor			Fine motor			Problem solving			Personal-social			
			1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4
Communication		39.1	<input type="radio"/>															
Gross motor		32.9	<input type="radio"/>															
Fine motor		30.0	<input type="radio"/>															
Problem solving		35.0	<input type="radio"/>															
Personal-social		23.4	<input type="radio"/>															
			Y	S	N	Y	S	N	Y	S	N	Y	S	N	Y	S	N	

Administering program or provider: _____

Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghée Kim**
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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.



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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[®] SETM

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 checked="" 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> x	<input type="radio"/>	
14. Do you and your child enjoy mealtimes together?		<input type="checkbox"/> z <input type="checkbox"/> v <input checked="" 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 checked="" type="checkbox"/> x	<input type="radio"/>	
16. Does your child seem more active than other children his age?		<input checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
23. Does your child hurt herself on purpose?	<input checked="" 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 checked="" type="checkbox"/> x	<input type="radio"/>
25. Does your child destroy or damage things on purpose?	<input checked="" 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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input checked="" type="checkbox"/> x	<input type="radio"/>
27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input checked="" type="checkbox"/> x	<input type="radio"/>
28. Do <i>other</i> children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input checked="" type="checkbox"/> x	<input type="radio"/>
29. Does <i>your child</i> like to play with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input checked="" type="checkbox"/> x	<input type="radio"/>
30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input checked="" type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
31. Does your child take turns and share when playing with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input checked="" type="checkbox"/> x	<input type="radio"/>
32. Does your child show an interest or knowledge of sexual language and activity?	<input checked="" type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
33. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	<input checked="" type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>



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?
