



South Lake Pediatrics
Infant, Child & Adolescent Care
952-401-8300
www.southlakepediatrics.com

24 Month/2 Year ASQ:SE Questionnaire

(For children ages 21 through 26 months)

Date: _____

Patient Name: _____
(Place label here)

Date of Birth: _____

Name of Person Completing Form: _____

Relationship to Patient: _____

.....

Please read carefully before completing this form.

The purpose of the ASQ:SE is to gain information on your child's social and emotional development and your feelings about your child's development. Some of the questions are not very specific, but you should answer based on your feelings or opinions about your child's behavior.

With the exception of the open-ended questions at the end of the questionnaire, each question has three possible answer responses, which should be checked as appropriate:

- *Most of the time*, indicating the child is doing the behavior most of the time, too much, or too often
- *Sometimes*, indicating the child is doing the behavior occasionally but not consistently
- *Rarely or Never*, indicating the child rarely performs the behavior or has never performed the behavior

If the behavior is of concern, you may also check the circle to the right of the question. It could be a rare or never occurrence but still is concerning when it does happen. Or it may just be something you want to discuss further.

06/2009

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

 z v x

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

 z v x

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

 x v z

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

 z v x

23. Does your child hurt himself on purpose?

 x v z

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

 z v x

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

 x v z

TOTAL POINTS ON PAGE ____

MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
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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 ____