



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

6 Month ASQ:SE Questionnaire

(For infant's ages 6 through 8 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. 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 ____