

The first 5 years of your child's life are very important. Your child's healthy social-emotional development forms a foundation for lifelong learning. ASQ:SE-2 is a set of questionnaires about behavior and social-emotional development in young children. There are nine questionnaires for different ages to screen children from 1 month to 6 years old.

ASQ:SE has been used by parents for more than 15 years. It makes sure that children's social-emotional development is on schedule. It helps you celebrate milestones while addressing any concerns as early as possible. ASQ:SE-2 can help identify your child's social-emotional strengths and areas where your child may need support.

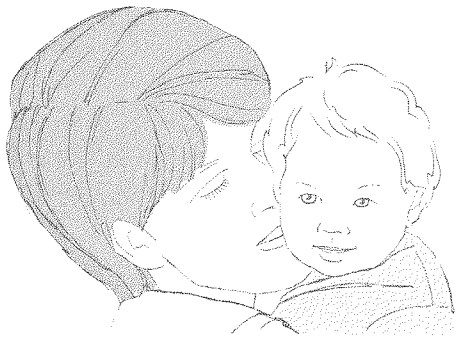
As a parent or caregiver, you are the best source of information about your child. That's why ASQ:SE-2 is designed for you to complete. You will only need 10–15 minutes. It's that quick and easy. Here's how ASQ:SE-2 works:

- Answer each question by marking "often or always," "sometimes," or "rarely or never." Answer based on what you know about your child.
- Note if any behaviors concern you.
- Remember that your answers help show your child's strengths and areas where he or she may need support.
- After you finish, your child's provider will discuss the results with you.

If your child's social-emotional development is on target, then there is nothing more you need to do. If there are concerns, then the provider will help you with next steps. When children get support as early as possible for behavioral concerns, problem behaviors may be prevented from getting more difficult as children get older.

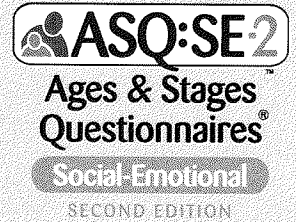
You play an important role in your child's learning and development. Completing ASQ:SE-2 questionnaires helps you make sure your child is off to a great start!

**To find out more, please talk to your
health care or education professional,
or visit www.agesandstages.com.**



24 Month Questionnaire

21 months 0 days through 26 months 30 days



Date ASQ:SE-2 completed: _____

Child's information

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

Child's date of birth: _____

Child's gender: Male Female

Person filling out questionnaire

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

Street address: _____

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

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

E-mail address: _____

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

People assisting in questionnaire completion: _____

Program information

(For program use only.)

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

Program ID #: _____

Program name: _____

24 Month QUESTIONNAIRE 21 months 0 days through 26 months 30 days



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

Important Points to Remember:

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


| | OFTEN OR ALWAYS | SOME-TIMES | RARELY OR NEVER | CHECK IF THIS IS A CONCERN | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|-------|
| 1. Does your child look at you when you talk to him? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 2. Does your child seem too friendly with strangers? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 3. Does your child laugh or smile when you play with her? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 4. Is your child's body relaxed? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 5. When you leave, does your child stay upset and cry for more than an hour? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 6. Does your child greet or say hello to familiar adults? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 7. Does your child like to be hugged or cuddled? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 8. When upset, can your child calm down within 15 minutes? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |

TOTAL POINTS ON PAGE _____

24 Month Questionnaire



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



| | OFTEN OR ALWAYS | SOME-TIMES | RARELY OR NEVER | CHECK IF THIS IS A CONCERN | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|-------|
| 9. Does your child stiffen and arch his back when picked up? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 10. Is your child interested in things around her, such as people, toys, and foods? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
|  | | | | | |
| 11. Does your child cry, scream, or have tantrums for long periods of time? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 12. Do you and your child enjoy mealtimes together? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 13. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| _____ | | | | | |
| _____ | | | | | |
| 14. Does your child sleep at least 10 hours in a 24-hour period? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 15. When you point at something, does your child look in the direction you are pointing? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 16. Does your child have trouble falling asleep at naptime or at night? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 17. Does your child get constipated or have diarrhea? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |

TOTAL POINTS ON PAGE _____

24 Month Questionnaire



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| | OFTEN OR ALWAYS | SOME-TIMES | RARELY OR NEVER | CHECK IF THIS IS A CONCERN | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|-------|
| 18. Does your child follow simple directions? For example, does she sit down when asked? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 19. Does your child let you know how he is feeling with words or gestures? For example, does he let you know when he is hungry, hurt, or tired? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 21. Does your child do things over and over and get upset when you try to stop her? For example, does she rock, flap her hands, spin, or _____? (Please describe.) _____ _____ | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 22. Does your child like to hear stories or sing songs?  | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 23. Does your child hurt himself on purpose? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 24. Does your child like to be around other children? For example, does she move close to or look at other children?  | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 26. Does your child try to show you things by pointing at them and looking back at you? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |

TOTAL POINTS ON PAGE _____

24 Month Questionnaire



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

| | OFTEN OR ALWAYS | SOME-TIMES | RARELY OR NEVER | CHECK IF THIS IS A CONCERN | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|-------|
| 27. Does your child play with objects by pretending? For example, does your child pretend to talk on the phone, feed a doll, or fly a toy airplane? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 28. Does your child wake three or more times during the night? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 29. Does your child respond to his name when you call him? For example, does he turn his head and look at you? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 30. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____ | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 31. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____ | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |

TOTAL POINTS ON PAGE _____

OVERALL Use the space below for additional comments.

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

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

34. What do you enjoy about your child?
