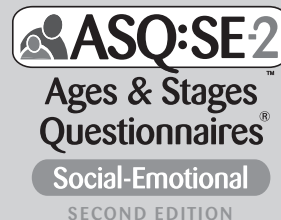




12 Month Questionnaire

9 months 0 days through 14 months 30 days



Date ASQ:SE-2 completed: _____

Baby's information

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

Baby's date of birth: _____ If baby was born 3 or more weeks premature, please enter the number of weeks: _____

Baby'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 baby: ☐ Parent ☐ Guardian ☐ Teacher ☐ Other: _____
☐ Grandparent/other relative ☐ Foster parent ☐ Child care provider

People assisting in questionnaire completion: _____

Program information

(For program use only.)

| | |
|---------------|--|
| Baby's ID #: | Age at administration in months and days: |
| Program ID #: | If premature, adjusted age in months and days: |
| Program name: | |



12 Month Questionnaire 9 months 0 days through 14 months 30 days



Questions about behaviors babies may have are listed on the following pages. Please read each question carefully and check the box ☒ that best describes your baby'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 baby's behavior.
- ☐ Answer questions based on your baby's *usual* behavior, not behavior when your baby is sick, very tired, or hungry.
- ☐ Caregivers who know the baby well and spend more than 15–20 hours per week with the baby should complete ASQ:SE-2.
- ☐ Please return this questionnaire by: _____
- ☐ If you have any questions or concerns about your baby 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 baby laugh or smile at you and other family members? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
|  | | | | | |
| 2. Does your baby look for you when a stranger comes near? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 3. Does your baby like to play near or be with family and friends? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 4. Does your baby like to be picked up and held? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 5. When upset, can your baby calm down within a half hour? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 6. Does your baby stiffen and arch her back when picked up? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 7. Does your baby like to play games such as Peekaboo? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
|  | | | | | |

TOTAL POINTS ON PAGE _____

12 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 | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|-------|
| 8. Is your baby's body relaxed? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 9. Does your baby 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 | _____ |
| 10. Is your baby able to calm himself down (for example, by sucking his hand or pacifier)? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| | | | | | |
| 11. Is your baby 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 | _____ |
| 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"/> v | _____ |
| 13. Do you and your baby enjoy mealtimes together? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 14. Does your baby have any eating problems, such as gagging, vomiting, or _____? (Please describe.) | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| _____ | | | | | |
| _____ | | | | | |
| 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"/> v | _____ |
| 16. Does your baby make babbling sounds? For example, does he put sounds together such as "ba-ba-ba-ba" or "na-na-na-na"? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |

TOTAL POINTS ON PAGE _____

12 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 | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|-------|
| 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"/> v | _____ |
| 18. Does your baby get constipated or have diarrhea? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 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"/> v | _____ |
| 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"/> v | _____ |
| 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"/> v | _____ |
| 22. Does your baby try to show you things? For example, does she hold out a toy and look at you? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 23. Does your baby 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 | _____ |
| 24. When you point at something, does your baby look in the direction you are pointing? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 25. Does your baby make sounds or use gestures to let you know she wants something (for example, by reaching)? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 26. When you copy sounds your baby makes, does your baby repeat the same sounds back to you? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 27. Has anyone shared concerns about your baby'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 | _____ |
| <div></div> <div></div> <div></div> | | | | | |

TOTAL POINTS ON PAGE _____

OVERALL Use the space below for additional comments.

28. Do you have concerns about your baby's eating or sleeping behaviors? If yes, please explain:

☐ YES

☐ NO

29. Does anything about your baby worry you? If yes, please explain:

☐ YES

☐ NO

30. What do you enjoy about your baby?

12 Month Information Summary 9 months 0 days through 14 months 30 days



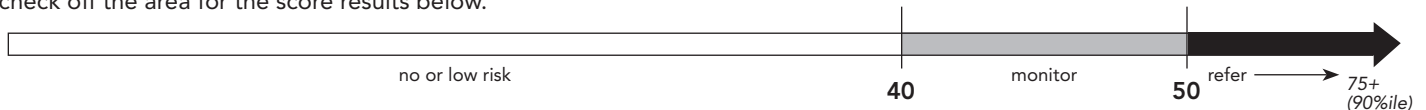
Baby's name: _____ Date ASQ:SE-2 completed: _____
 Baby's ID #: _____ Baby's date of birth: _____
 Person who completed ASQ:SE-2: _____ Baby's age/adjusted age in months and days: _____
 Administering program/provider: _____ Baby's gender: ☐ Male ☐ Female

1. ASQ:SE-2 SCORING CHART:

- Score items ($Z = 0$, $V = 5$, $X = 10$, *Concern* = 5).
- Transfer the page totals and add them for the total score.
- Record the baby's total score next to the cutoff.

| | | | |
|------------------------|--|--------|-------------|
| TOTAL POINTS ON PAGE 1 | | Cutoff | Total score |
| TOTAL POINTS ON PAGE 2 | | | |
| TOTAL POINTS ON PAGE 3 | | 50 | |
| Total score | | | |

2. ASQ:SE-2 SCORE INTERPRETATION: Review the approximate location of the baby's total score on the scoring graphic. Then, check off the area for the score results below.



- ___ The baby's total score is in the ☐ area. It is below the cutoff. Social-emotional development appears to be on schedule.
- ___ The baby's total score is in the ☐ area. It is close to the cutoff. Review behaviors of concern and monitor.
- ___ The baby's total score is in the ☐ area. It is above the cutoff. Further assessment with a professional may be needed.

3. OVERALL RESPONSES AND CONCERNS: Record responses and transfer parent/caregiver comments. YES responses require follow-up.

- 1–27. Any Concerns marked on scored items? **YES** no Comments: _____
28. Eating/sleeping concerns? **YES** no Comments: _____
29. Other worries? **YES** no Comments: _____

4. FOLLOW-UP REFERRAL CONSIDERATIONS: Mark all as Yes, No, or Unsure (Y, N, U). See pages 98–103 in the ASQ:SE-2 User's Guide.

- ___ **Setting/time factors** (e.g., Is the baby's behavior the same at home as at school?)
- ___ **Developmental factors** (e.g., Is the baby's behavior related to a developmental stage or delay?)
- ___ **Health factors** (e.g., Is the baby's behavior related to health or biological factors?)
- ___ **Family/cultural factors** (e.g., Is the baby's behavior acceptable given the baby's cultural or family context? Have there been any stressful events in the baby's life recently?)
- ___ **Parent concerns** (e.g., Did the parent/caregiver express any concerns about the baby's behavior?)

5. FOLLOW-UP ACTION: Check all that apply.

- ___ Provide activities and rescreen in ___ months.
- ___ Share results with primary health care provider.
- ___ Provide parent education materials.
- ___ Provide information about available parenting classes or support groups.
- ___ Have another caregiver complete ASQ:SE-2. List caregiver here (e.g., grandparent, teacher): _____
- ___ Administer developmental screening (e.g., ASQ-3).
- ___ Refer to early intervention/early childhood special education.
- ___ Refer for social-emotional, behavioral, or mental health evaluation.
- ___ Other: _____