

15 Month ASQ:SE Questionnaire

(For children ages 15 through 20 months)

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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: _____



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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input 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 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 type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
13. 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"/>
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 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"/>
16. 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"/>
17. Does your child 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
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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?

 z v x

19. Does your child follow simple directions? For example, does he sit down when asked?

 z v x

20. Does your child like to play near or be with family members and friends?

 z v x

21. 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

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

 z v x

23. Does your child hurt herself 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
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CHECK IF
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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 ____

15 Month ASQ:SE Information Summary

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

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
18 months	50	

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?, Have there been any stressful events in the child's life recently?)
 - 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?)