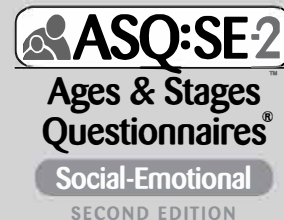




# 36 Month Questionnaire

33 months 0 days through 41 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:	

# 36 Month Questionnaire 33 months 0 days through 41 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 her?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. 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	_____
3. Does your child talk or play with adults he knows well?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. Does your child cling to you more than you expect?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
5. 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	_____
6. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
7. Does your child settle herself down after exciting activities?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE \_\_\_\_\_

# 36 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. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
9. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
10. Is your child interested in things around him, 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 do what you ask her to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
12. Does your child seem more active than other children his age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
13. Does your child stay with activities she enjoys for at least 5 minutes (other than watching shows or videos, or playing with electronics)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
15. 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	_____
16. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
17. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE \_\_\_\_\_

# 36 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	
18. Does your child follow routine directions? For example, does he come to the table or help clean up his toys when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
19. 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	_____
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	_____
<div data-bbox="779 619 860 840" data-label="Image"> </div>					
22. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
23. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
24. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
25. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
26. Can your child name a friend?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

# 36 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. Do <i>other</i> children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Does your <i>child</i> like to play with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
29. 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	_____
30. Does your child show an unusual interest in or knowledge of sexual language and activity?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
31. 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	_____
32. Does your child pretend objects are something else? For example, does he pretend a banana is a phone?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
33. 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	_____
34. 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	_____
35. 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.

36. Do you have concerns about your child's eating, sleeping, or toileting habits?  
If yes, please explain:

☐ YES ☐ NO

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37. Does anything about your child worry you? If yes, please explain:

☐ YES ☐ NO

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38. What do you enjoy about your child?

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# 36 Month Information Summary 33 months 0 days through 41 months 30 days



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

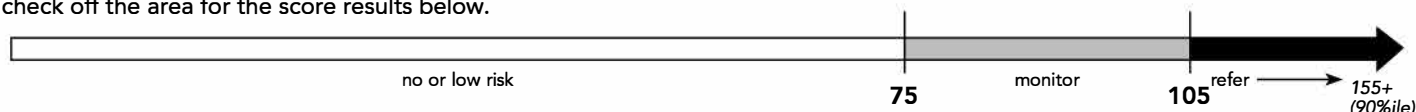
## 1. ASQ:SE-2 SCORING CHART:

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

TOTAL POINTS ON PAGE 1	
TOTAL POINTS ON PAGE 2	
TOTAL POINTS ON PAGE 3	
TOTAL POINTS ON PAGE 4	
<b>Total score</b>	

Cutoff	Total score
<b>105</b>	

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



- \_\_\_ The child's total score is in the ☐ area. It is below the cutoff. Social-emotional development appears to be on schedule.  
 \_\_\_ The child's total score is in the ☐ area. It is close to the cutoff. Review behaviors of concern and monitor.  
 \_\_\_ The child'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.

- 1-35. Any Concerns marked on scored items? **YES** no Comments: \_\_\_\_\_
36. Eating/sleeping/toileting concerns? **YES** no Comments: \_\_\_\_\_
37. 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 child's behavior the same at home as at school?)  
 \_\_\_ **Developmental factors** (e.g., Is the child's behavior related to a developmental stage or 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 the child's cultural or family context? Have there been any stressful events in the child's life recently?)  
 \_\_\_ **Parent concerns** (e.g., Did the parent/caregiver express any concerns about the child'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.  
 \_\_\_ Follow up with items of concern.  
 \_\_\_ Other: \_\_\_\_\_