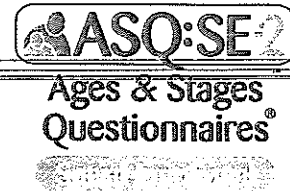


6 Month Questionnaire

3 months 0 days through 8 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: | |

6 Month Questionnaire 3 months 0 days through 8 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. When upset, can your baby calm down within a half hour? | <input type="checkbox"/> z | <input type="checkbox"/> y | <input type="checkbox"/> x | <input type="radio"/> y | _____ |
| 2. Does your baby smile at you and other family members? | <input type="checkbox"/> z | <input type="checkbox"/> y | <input type="checkbox"/> x | <input type="radio"/> y | _____ |
| 3. Does your baby like to be picked up and held? | <input type="checkbox"/> z | <input type="checkbox"/> y | <input type="checkbox"/> x | <input type="radio"/> y | _____ |
| 4. Does your baby stiffen and arch her back when picked up? | <input type="checkbox"/> x | <input type="checkbox"/> y | <input type="checkbox"/> z | <input type="radio"/> y | _____ |
| 5. When you talk to your baby, does he look at you and seem to listen? | <input type="checkbox"/> z | <input type="checkbox"/> y | <input type="checkbox"/> x | <input type="radio"/> y | _____ |
| 6. Does your baby let you know when she is hungry or sick? | <input type="checkbox"/> z | <input type="checkbox"/> y | <input type="checkbox"/> x | <input type="radio"/> y | _____ |
| 7. Does your baby seem to enjoy watching or listening to people? For example, does he turn his head to look at someone talking? | <input type="checkbox"/> z | <input type="checkbox"/> y | <input type="checkbox"/> y | <input type="radio"/> y | _____ |




TOTAL POINTS ON PAGE _____

6 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 able to calm herself down (for example, by sucking her hand or pacifier)?  | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> k | <input type="radio"/> v | _____ |
| 9. Does your baby cry for long periods of time? | <input type="checkbox"/> k | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 10. Is your baby's body relaxed? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> k | <input type="radio"/> v | _____ |
| 11. Does your baby have trouble sucking from a breast or bottle? | <input type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <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 feeding times together? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> k | <input type="radio"/> v | _____ |
| 14. Does your baby have any eating problems, such as gagging, vomiting, or _____? (Please describe.) _____ _____ | <input type="checkbox"/> k | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> v | _____ |
| 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"/> k | <input type="radio"/> v | _____ |
| 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"/> v | _____ |

TOTAL POINTS ON PAGE _____

6 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 make sounds and look at you while playing with you? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 20. Does your baby make sounds or use gestures to get your attention? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 21. When you smile at your baby, does he smile back at you? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 22. When you talk or make sounds to your baby, does she make sounds back? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> v | _____ |
| 23. 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 | _____ |

TOTAL POINTS ON PAGE _____

OVERALL Use the space below for additional comments.

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

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

26. What do you enjoy about your baby?

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:

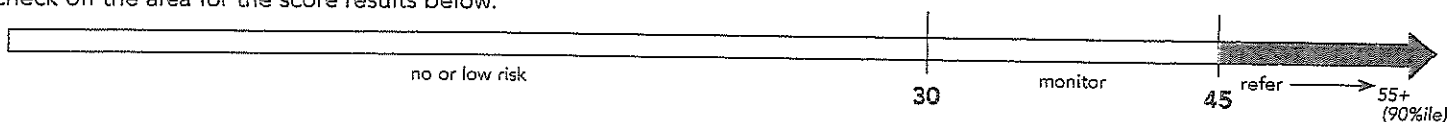
- Score items (Z = 0, V = 5, X = 10, Concern = 5).
- Transfer the page totals and add them for the total score.
- Record the baby's total score next to the cutoff.

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

| Cutoff | Total score |
|--------|-------------|
| 45 | |

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.

- 1-23. Any Concerns marked on scored items? **YES** no Comments: _____
24. Eating/sleeping concerns? **YES** no Comments: _____
25. 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: _____