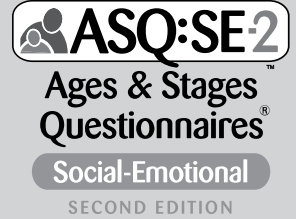




# 12 Month Questionnaire

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:<br>_____<br>_____<br>_____       | <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.

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

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

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30. What do you enjoy about your baby?

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



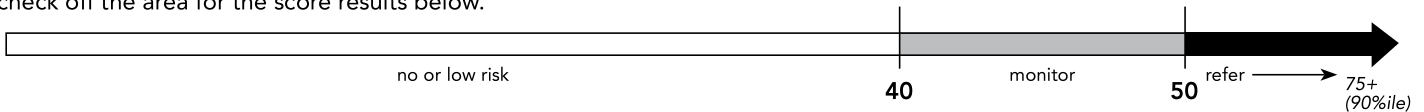
Baby's name: \_\_\_\_\_ Date ASQ:SE-2 completed: \_\_\_\_\_  
 Baby's ID #: \_\_\_\_\_ Baby's date of birth: \_\_\_\_\_  
 Person who completed ASQ:SE-2: \_\_\_\_\_ Baby's age/adjusted age in months and days: \_\_\_\_\_  
 Administering program/provider: \_\_\_\_\_ Baby's gender:  Male  Female

## 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 |  |           |             |
| <b>Total score</b>     |  |           |             |
|                        |  | <b>50</b> |             |

## 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: \_\_\_\_\_