

Ages & Stages Questionnaires®: Social-Emotional  
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors  
By Jane Squires, Diane Bricker, & Elizabeth Twombly  
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim  
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# 24 Month/2 Year Questionnaire



(For children ages 21 through 26 months)

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*Important Points to Remember:*

- Please return this questionnaire by \_\_\_\_\_ .
- If you have any questions or concerns about your child or about this questionnaire, please call: \_\_\_\_\_ .
- Thank you and please look forward to filling out another ASQ:SE questionnaire in \_\_\_\_\_ months.



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# 24 Month/2 Year ASQ:SE Questionnaire

(For children ages 21 through 26 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
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1. Does your child look at you when you talk to him?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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2. Does your child seem too friendly with strangers?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
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3. Does your child laugh or smile when you play with her?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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4. Is your child's body relaxed?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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5. When you leave, does your child remain upset and cry for more than an hour?



<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
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6. Does your child greet or say hello to familiar adults?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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7. Does your child like to be hugged or cuddled?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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8. 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"/>
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9. Does your child stiffen and arch his back when picked up?

<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 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 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"/>
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
13. 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"/>
14. 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"/>
15. 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"/>
16. 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"/>
17. Does your child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
18. Does your child follow simple directions? For example, does he sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
TOTAL POINTS ON PAGE				—

MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
------------------	-----------	-----------------	----------------------------

19. Does your child let you know how she is feeling with either words or gestures? For example, does she let you know when she is hungry, hurt, or tired?

z       v       x     

20. 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     

21. 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.)

x       v       z     

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



z       v       x     

23. Does your child hurt himself 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  
NEVER

CHECK IF  
THIS IS A  
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

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27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

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28. Is there anything that worries you about your child? If so, please explain:

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29. What things do you enjoy most about your child?

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

# 24 Month/2 Year ASQ:SE Information Summary

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Person filling out the ASQ:SE: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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## 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 40 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 40–42 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
24 months/2 years	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 45–50 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?)