

6 Month ASQ:SE Questionnaire

(For infants ages 3 through 8 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. When upset, can your baby calm down within a half hour?

 z

 v

 x

2. Does your baby smile at you and other family members?


 z

 v

 x

3. Does your baby like to be picked up and held?

 z

 v

 x

4. Does your baby stiffen and arch her back when picked up?

 x

 v

 z

5. When talking to your baby, does he look at you and seem to be listening?

 z

 v

 x

6. Does your baby let you know when she is hungry or sick?

 z

 v

 x

7. When awake, does your baby seem to enjoy watching or listening to people?

 z

 v

 x

8. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)?


 z

 v

 x

9. Does your baby cry for long periods of time?

 x

 v

 z

10. Is your baby's body relaxed?

 z

 v

 x

TOTAL POINTS ON PAGE ____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
11. Does your baby have trouble sucking from a bottle or breast?	<input checked="" type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
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"/>
13. Do you and your baby enjoy mealtimes together (including breast and bottle feeding)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. Does your baby have any eating problems, such as gagging, vomiting, or _____ ? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
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"/> x	<input type="radio"/>
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"/>
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"/>
18. Does your baby 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 THIS IS A CONCERN
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19. Has anyone expressed concerns about your baby's behavior? If you checked "sometimes" or "most of the time," please explain:

<input checked="" type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
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20. Do you have concerns about your baby's eating or sleeping behaviors? If so, please explain:

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

22. What things do you enjoy most about your baby?

TOTAL POINTS ON PAGE ____

6 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 = _____
 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
6 months	45	

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?)