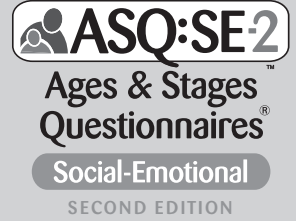




# 18 Month Questionnaire

15 months 0 days through 20 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: \_\_\_\_\_ If child was born 3 or more weeks premature, please enter the number of weeks: \_\_\_\_\_

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 #:	If premature, adjusted age in months and days:
Program name:	


# 18 Month Questionnaire 15 months 0 days through 20 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 him?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. When you leave, does your child stay upset and cry for more than an hour?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
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"/> v	_____
					
4. Does your child look for you when a stranger comes near?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. Is your child's body relaxed?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. 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	_____
7. 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	_____

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

# 18 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 stiffen and arch his back when picked up?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
9. 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	_____
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"/> v	_____
11. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
12. Does your child have eating problems? For example, does she 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	_____
13. 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"/> 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 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	_____
16. 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"/> v	_____

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

# 18 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 child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
18. Does your child let you know how he is feeling with gestures or words? For example, does he let you know when he is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
19. Does your child follow simple directions? For example, does she sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
20. Does your child 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	_____
21. 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	_____
22. Does your child like to hear stories or sing songs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
23. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
24. Does your child like to be around other children? For example, does she move close to or look at other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
25. 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	_____

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

# 18 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	
26. 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	_____
27. Does your child make sounds or use words or gestures to let you know he wants something (for example, by reaching)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Does your child play with objects by pretending? For example, does your child pretend to talk on the phone, feed a doll, or fly a toy airplane?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
29. 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	_____
30. Does your child respond to her name when you call her? For example, does she turn her head and look at you?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
31. 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.

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

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

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34. What do you enjoy about your child?

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