

# 18 Month Questionnaire

(For children ages 15 through 20 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.



This Screening is billed to your insurance. If you have commercial insurance it may or may not be a covered benefit.

# 18 Month ASQ:SE Questionnaire

(For children ages 15 through 20 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. 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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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. Does your child look for you when a stranger approaches?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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5. 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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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"/>
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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"/>
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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"/>
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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"/>
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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 do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
12. 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"/>
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"/>
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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"/>
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"/>
17. Does your child 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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18. Does your child let you know how she is feeling with gestures or words? For example, does she 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"/>
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19. 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"/>
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20. Does your child like to play near or be with family members and friends?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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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"/>
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22. Does your child like to hear stories or sing songs?

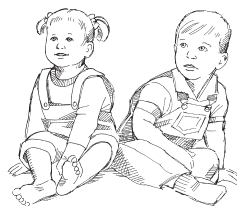


<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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23. Does your child hurt herself on purpose?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
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24. Does your child like to be around other children?



<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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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"/>
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TOTAL POINTS ON PAGE \_\_\_\_

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