60 Month/5 Year Questionnaire
(For children ages 54 through 65 months)

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 for your participation in this project.
60 Month/5 Year ASQ:SE Questionnaire

(For children ages 54 through 65 months)

Parent Questionnaire

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

<table>
<thead>
<tr>
<th>Question</th>
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<th>SOMETIMES</th>
<th>RARELY OR NEVER</th>
<th>CHECK IF THIS IS A CONCERN</th>
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</thead>
<tbody>
<tr>
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<td>☐ V</td>
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☐ Z  ☐ V  ☐ X  ○

11. Does your child go to the bathroom by herself? (Reminders and help with wiping are okay.)  
☐ Z  ☐ V  ☐ X  ○

12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or ________________________? (You may write in another problem.)  
☐ X  ☐ V  ☐ Z  ○

13. Can your child stay with activities he enjoys for at least 15 minutes (not including watching television)?  
☐ Z  ☐ V  ☐ X  ○

14. Do you and your child enjoy mealtimes together?  
☐ Z  ☐ V  ☐ X  ○

15. Does your child do what you ask her to do?  
☐ Z  ☐ V  ☐ X  ○

16. Does your child seem more active than other children his age?  
☐ X  ☐ V  ☐ Z  ○

17. Does your child sleep at least 8 hours in a 24-hour period?  
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<tr>
<td>19.</td>
<td>Does your child use words to describe his feelings and the feelings of others, such as, “I’m happy,” “I don’t like that,” or “She’s sad”?</td>
<td>☐ Z</td>
<td>☐ V</td>
<td>☐ X</td>
</tr>
<tr>
<td>20.</td>
<td>Does your child move from one activity to the next with little difficulty, such as from playtime to mealtime?</td>
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<td>22.</td>
<td>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.)</td>
<td>☐ X</td>
<td>☐ V</td>
<td>☐ Z</td>
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<td>23.</td>
<td>Does your child hurt herself on purpose?</td>
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<td>☐ V</td>
<td>☐ Z</td>
</tr>
<tr>
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<tr>
<td>28.</td>
<td>Do other children like to play with your child?</td>
<td>☐ Z</td>
<td>☐ V</td>
<td>☐ X</td>
</tr>
<tr>
<td>29.</td>
<td>Does your child like to play with other children?</td>
<td>☐ Z</td>
<td>☐ V</td>
<td>☐ X</td>
</tr>
<tr>
<td>30.</td>
<td>Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?</td>
<td>☐ X</td>
<td>☐ V</td>
<td>☐ Z</td>
</tr>
<tr>
<td>31.</td>
<td>Does your child take turns and share when playing with other children?</td>
<td>☐ Z</td>
<td>☐ V</td>
<td>☐ X</td>
</tr>
<tr>
<td>32.</td>
<td>Does your child show an interest or knowledge of sexual language and activity?</td>
<td>☐ X</td>
<td>☐ V</td>
<td>☐ Z</td>
</tr>
<tr>
<td>33.</td>
<td>Has anyone expressed concerns about your child's behaviors? If you checked “sometimes” or “most of the time,” please explain:</td>
<td>☐ X</td>
<td>☐ V</td>
<td>☐ Z</td>
</tr>
</tbody>
</table>

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TOTAL POINTS ON PAGE ___.

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
**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 = _____
   - 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).

<table>
<thead>
<tr>
<th>Questionnaire interval</th>
<th>Cutoff score</th>
<th>Child’s ASQ:SE score</th>
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<tbody>
<tr>
<td>60 months/5 years</td>
<td>70</td>
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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?)
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 for your participation in this project.
60 Month/5 Year ASQ:SE Questionnaire

(For children ages 54 through 65 months)

Preschool Provider Questionnaire

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

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