

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

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

1. Does your child look at you when you talk to her?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

2. Does your child cling to you more than you expect?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

3. Does your child like to be hugged or cuddled?



<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

4. Does your child talk and/or play with adults he knows well?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

5. 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"/>
----------------------------	----------------------------	----------------------------	-----------------------

6. Does your child seem too friendly with strangers?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

7. Can your child settle herself down after periods of exciting activity?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

8. Does your child seem happy?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

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"/>
----------------------------	----------------------------	----------------------------	-----------------------

TOTAL POINTS ON PAGE ____

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

10. Is your child interested in things around him, such as people, toys, and foods?



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?

z v x

TOTAL POINTS ON PAGE ____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. 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"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your child explore 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"/>
22. 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"/>
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
24. Does your child follow rules (at home, at child care)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
25. Does your child destroy or damage things on purpose?	<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
------------------	-----------	-----------------	----------------------------

26. Does your child stay away from dangerous things, such as fire and moving cars?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

28. Do *other* children like to play with your child?



<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

29. Does *your child* like to play with other children?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

30. 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"/>
----------------------------	----------------------------	----------------------------	-----------------------

31. Does your child take turns and share when playing with other children?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

32. Does your child show an interest or knowledge of sexual language and activity?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

33. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

TOTAL POINTS ON PAGE ____

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?

60 Month/5 Year 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 = _____
 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
60 months/5 years	70	

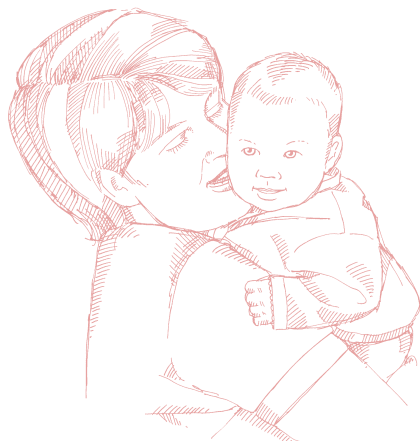
3. Referral criteria

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?)



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)

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

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

1. Does your child look at you when you talk to her?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

2. Does your child cling to you more than you expect?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

3. Does your child like to be hugged or cuddled?



<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

4. Does your child talk and/or play with adults he knows well?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

5. 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"/>
----------------------------	----------------------------	----------------------------	-----------------------

6. Does your child seem too friendly with strangers?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

7. Can your child settle herself down after periods of exciting activity?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

8. Does your child seem happy?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

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"/>
----------------------------	----------------------------	----------------------------	-----------------------

TOTAL POINTS ON PAGE ____

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

10. Is your child interested in things around him, such as people, toys, and foods?



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?

z v x

TOTAL POINTS ON PAGE ____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. 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"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your child explore 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"/>
22. 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"/>
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
24. Does your child follow rules (at home, at child care)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
25. Does your child destroy or damage things on purpose?	<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
------------------	-----------	-----------------	----------------------------

26. Does your child stay away from dangerous things, such as fire and moving cars?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

28. Do *other* children like to play with your child?



<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

29. Does *your child* like to play with other children?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

30. 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"/>
----------------------------	----------------------------	----------------------------	-----------------------

31. Does your child take turns and share when playing with other children?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

32. Does your child show an interest or knowledge of sexual language and activity?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

33. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

TOTAL POINTS ON PAGE ____

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?

60 Month/5 Year 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 = _____
 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
60 months/5 years	70	

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?)