



# 48 Month/4 Year Questionnaire



(For children ages 42 through 53 months)



## *Important Points to Remember:*

- ☒ Please return this questionnaire by 5/15/09 .
- ☒ If you have any questions or concerns about your child or about this questionnaire, please call: Anytown Preschool .
- ☒ Thank you and please look forward to filling out another ASQ:SE questionnaire in 12 months.



# 48 Month/4 Year ASQ:SE Questionnaire

(For children ages 42 through 53 months)

Please provide the following information.

Child's name: Emily Martin

Child's date of birth: 6/28/05

Today's date: 4/30/09

Person filling out this questionnaire: Julia and Paul Martin

What is your relationship to the child? Mother and Father

Your telephone: 410-555-0111

Your mailing address: 123 First St., Apt 1

City: Anytown

State: MD ZIP code: 21230

List people assisting in questionnaire completion: \_\_\_\_\_

Administering program or provider: Anytown Preschool



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 him?

☒ z

☐ v

☐ x

☐

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

☐ x

☐ v

☒ z

☐

3. Does your child talk and/or play with adults she knows well?

☐ z

☒ v

☐ x

☐

4. When upset, can your child calm down within 15 minutes?

☒ z

☐ v

☐ x

☐

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

☐ z

☒ v

☐ x

☐

6. Does your child seem too friendly with strangers?

☐ x

☐ v

☒ z

☐

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

☒ z

☐ v

☐ x

☐

8. Does your child cry, scream, or have tantrums for long periods of time?

☐ x

☐ v

☒ z

☐

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

☐ z

☒ v

☐ x

☐

TOTAL POINTS ON PAGE 15

|                                                                                                                                                     | MOST<br>OF THE<br>TIME                | SOMETIMES                             | RARELY<br>OR<br>NEVER                 | CHECK IF<br>THIS IS A<br>CONCERN |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|----------------------------------|
| 10. Does your child stay dry during the day?                                                                                                        | <input type="checkbox"/> z            | <input checked="" type="checkbox"/> v | <input type="checkbox"/> x            | <input checked="" type="radio"/> |
| 11. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ?<br>(You may write in another problem.) | <input type="checkbox"/> x            | <input type="checkbox"/> v            | <input checked="" type="checkbox"/> z | <input type="radio"/>            |
| 12. Do you and your child enjoy mealtimes together?                                                                                                 | <input type="checkbox"/> z            | <input type="checkbox"/> v            | <input checked="" type="checkbox"/> x | <input type="radio"/>            |
| 13. Does your child do what you ask her to do?                                                                                                      | <input checked="" type="checkbox"/> z | <input type="checkbox"/> v            | <input type="checkbox"/> x            | <input type="radio"/>            |
| 14. Does your child seem happy?                                                                                                                     | <input checked="" type="checkbox"/> z | <input type="checkbox"/> v            | <input type="checkbox"/> x            | <input type="radio"/>            |
| 15. Does your child sleep at least 8 hours in a 24-hour period?                                                                                     | <input checked="" type="checkbox"/> z | <input type="checkbox"/> v            | <input type="checkbox"/> x            | <input type="radio"/>            |
| 16. Does your child seem more active than other children his age?                                                                                   | <input type="checkbox"/> x            | <input type="checkbox"/> v            | <input checked="" type="checkbox"/> z | <input type="radio"/>            |
| 17. Does your child use words to tell you what she wants or needs?                                                                                  | <input type="checkbox"/> z            | <input checked="" type="checkbox"/> v | <input type="checkbox"/> x            | <input type="radio"/>            |
| 18. Can your child stay with activities he enjoys for at least 10 minutes (not including watching television)?                                      | <input checked="" type="checkbox"/> z | <input type="checkbox"/> v            | <input type="checkbox"/> x            | <input type="radio"/>            |

TOTAL POINTS ON PAGE **25**

|                                                                                                                                                                     | MOST<br>OF THE<br>TIME                | SOMETIMES                             | RARELY<br>OR<br>NEVER                 | CHECK IF<br>THIS IS A<br>CONCERN |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|----------------------------------|
| 19. Does your child use words to describe her 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 checked="" type="checkbox"/> x | <input type="radio"/>            |
| 20. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?                                                    | <input checked="" 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 checked="" 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 _____ .<br>(You may write in something else.) | <input type="checkbox"/> x            | <input type="checkbox"/> v            | <input checked="" type="checkbox"/> z | <input type="radio"/>            |
| 23. Does your child hurt himself on purpose?                                                                                                                        | <input type="checkbox"/> x            | <input type="checkbox"/> v            | <input checked="" type="checkbox"/> z | <input type="radio"/>            |
| 24. Does your child follow rules (at home, at child care)?                                                                                                          | <input checked="" 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 checked="" type="checkbox"/> z | <input type="radio"/>            |
| 26. Does your child stay away from dangerous things, such as fire and moving cars?                                                                                  | <input checked="" type="checkbox"/> z | <input type="checkbox"/> v            | <input type="checkbox"/> x            | <input type="radio"/>            |



TOTAL POINTS ON PAGE **15**

|                                                                                                                                   | MOST<br>OF THE<br>TIME                | SOMETIMES                             | RARELY<br>OR<br>NEVER                 | CHECK IF<br>THIS IS A<br>CONCERN |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|----------------------------------|
| 27. Can your child name a friend?                                                                                                 | <input type="checkbox"/> z            | <input checked="" type="checkbox"/> v | <input type="checkbox"/> x            | <input type="radio"/>            |
| 28. Does your child show concern for other people's feelings? For example, does she look sad when someone is hurt?                | <input checked="" type="checkbox"/> z | <input type="checkbox"/> v            | <input type="checkbox"/> x            | <input type="radio"/>            |
| 29. Do <i>other</i> children like to play with your child?                                                                        | <input type="checkbox"/> z            | <input checked="" type="checkbox"/> v | <input type="checkbox"/> x            | <input type="radio"/>            |
| 30. Does <i>your child</i> like to play with other children?                                                                      | <input type="checkbox"/> z            | <input checked="" type="checkbox"/> v | <input type="checkbox"/> x            | <input type="radio"/>            |
| 31. 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 checked="" type="checkbox"/> z | <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 checked="" 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 checked="" type="checkbox"/> z | <input type="radio"/>            |
| <hr/> <hr/> <hr/> <hr/>                                                                                                           |                                       |                                       |                                       |                                  |

TOTAL POINTS ON PAGE **15**



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

**She started to wet herself again**

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

**No**

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

**She's a really easy and nice kid**

# 48 Month/4 Year ASQ:SE Information Summary

Child's name: **Emily Martin** Child's date of birth: **6/28/05**  
 Person filling out the ASQ:SE: **Julia and Paul Martin** Relationship to child: **Parents**  
 Mailing address: **123 First St., Apt 1** City: **Anytown** State: **MD** ZIP: **21230**  
 Telephone: **410-555-0111** Assisting in ASQ:SE completion: \_\_\_\_\_  
 Today's date: **4/30/09** Administering program/provider: **Anytown Preschool**

## 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 | = <b>15</b> |
| Total points on page 4 | = <b>25</b> |
| Total points on page 5 | = <b>15</b> |
| Total points on page 6 | = <b>15</b> |
| Child's total score =  | <b>70</b>   |

## 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 |
|------------------------|--------------|----------------------|
| 48 months/4 years      | 70           | <b>70</b>            |

### 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?)