



30 Month Questionnaire

(For children ages 27 through 32 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.



30 Month ASQ:SE Questionnaire

(For children ages 27 through 32 months)

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 him?

☐ z

☐ v

☐ x

☐

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

☐ z

☐ v

☐ x

☐

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



☐ x

☐ v

☐ z

☐

4. Does your child greet or say hello to familiar adults?

☐ z

☐ v

☐ x

☐

5. Does your child seem happy?

☐ z

☐ v

☐ x

☐

6. Does your child like to hear stories and sing songs?

☐ z

☐ v

☐ x

☐

7. Does your child seem too friendly with strangers?

☐ x

☐ v

☐ z

☐

8. Does your child seem more active than other children her age?



☐ x

☐ v

☐ z

☐

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

☐ z

☐ v

☐ x

☐

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

☐ x

☐ v

☐ z

☐

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.)

☐ x

☐ v

☐ z

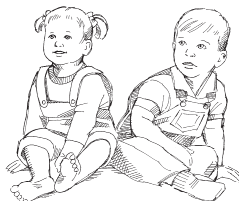
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TOTAL POINTS ON PAGE ____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
12. Can your child stay with activities she enjoys for at least 3 minutes (not including watching television)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
13. Does your child do what you ask him to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. 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"/>
15. 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"/>
16. 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"/>
17. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
18. 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"/>
19. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child let you know how he is feeling with either words or gestures? 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"/>
TOTAL POINTS ON PAGE ____				



	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
21. Does your child follow routine directions? For example, does she come to the table or help clean up her toys when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
22. 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"/>
23. Can 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"/>
24. 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"/>
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"/>
26. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
27. Does your child play alongside other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
28. 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"/>
TOTAL POINTS ON PAGE ____				



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

☒ x

☐ v

☐ z

☐

30. Do you have concerns about your child's eating and sleeping behaviors or about her toilet training? If so, please explain:

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

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

TOTAL POINTS ON PAGE ____