

4 Years Old (48 Months)

Child's Name _____ Date of Birth _____

Please read each question carefully and 1. Check the box <input type="checkbox"/> that best describes your child's behavior and 2. Check the circle <input type="radio"/> if this behavior is a concern	<i>Most of the Time</i>	<i>Sometimes</i>	<i>Rarely or never</i>	<i>Check if this is a concern</i>
1. Does your child look at you when you talk to him/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 talk and/or play with adults he/she knows well?	<input type="checkbox"/> Z	<input type="checkbox"/> V	<input type="checkbox"/> X	<input type="radio"/>
4. 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"/>
5. Does your child like to be hugged or cuddled?	<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 him/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 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"/>
9. Is your child interested in things around him /her, such as people, toys, and foods?	<input type="checkbox"/> Z	<input type="checkbox"/> V	<input type="checkbox"/> X	<input type="radio"/>
10. Does your child stay dry during the day?	<input type="checkbox"/> Z	<input type="checkbox"/> V	<input type="checkbox"/> X	<input type="radio"/>
11. 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"/>
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> Z	<input type="checkbox"/> V	<input type="checkbox"/> X	<input type="radio"/>

13. Does your child do what you ask her/him to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
14. Does your child seem happy?	<input 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 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/her age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
17. Does your child use words to tell you what he/she wants or needs?	<input type="checkbox"/> z	<input 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 type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. Does your child use words to describe her/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. 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"/>
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 him/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 childcare?)	<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 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. Can your child name a friend?	<input type="checkbox"/> Z	<input 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 type="checkbox"/> Z	<input type="checkbox"/> V	<input type="checkbox"/> X	<input type="radio"/>
29. Do other children like to play with your child?	<input type="checkbox"/> Z	<input type="checkbox"/> V	<input type="checkbox"/> X	
30. Does your child like to play with other children?	<input type="checkbox"/> Z	<input type="checkbox"/> V	<input type="checkbox"/> X	
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 type="checkbox"/> Z	<input type="radio"/>
32. Does your child show an interest in 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"/>
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34. Do you have any concerns about your child's eating, sleeping, or toileting habits? If so, please explain:	<hr/> <hr/> <hr/> <hr/>			
35. Is there anything that worries you about your child? If so, please explain:	<hr/> <hr/> <hr/> <hr/>			
36. What things do you enjoy most about your child?	<hr/> <hr/> <hr/>			

Total points on page 1 = _____

Total points on page 2 = _____

Total points on page 3 = _____

Child's total score = _____

Score Interpretation

Questionnaire Interval	Cut-Off Score	Child's ASQ-SE Score
36 months/3 years	59	
48 months/4 years	70	
60 months/5 years	70	