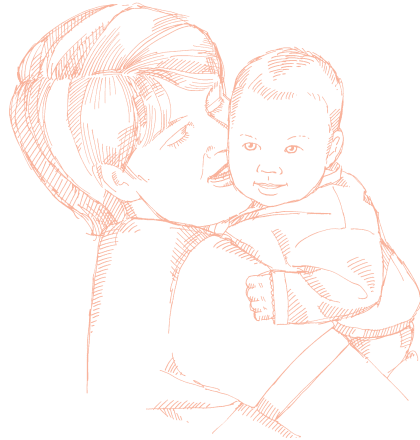


Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By Jane Squires, Diane Bricker, & Elizabeth Twombly
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim
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12 Month/1 Year Questionnaire



(For children ages 9 through 14 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 and please look forward to filling out another ASQ:SE questionnaire in _____ months.



12 Month/1 Year ASQ:SE Questionnaire

(For children ages 9 through 14 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 baby laugh or smile at you and other family members?



z v x

2. Does your baby look for you when a stranger approaches?

z v x

3. Does your baby like to play near and be with family members and friends?

z v x

4. Does your baby like to be picked up and held?

z v x

5. When upset, can your baby calm down within a half hour?

z v x

6. Does your baby stiffen and arch her back when picked up?

x v z

7. Does your baby like to play games like Peekaboo?



z v x

8. Is your baby's body relaxed?

z v x

9. Does your baby cry, scream, or have tantrums for long periods of time?

x v z

TOTAL POINTS ON PAGE ____

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

10. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)?



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

11. Is your baby 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"/> |
|----------------------------|----------------------------|----------------------------|-----------------------|

12. Does it take longer than 30 minutes to feed your baby?

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

13. Do you and your baby enjoy mealtimes together?

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

14. Does your baby have any eating problems, such as gagging, vomiting, or _____ ?
(You may write in another problem.)

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

15. Does your baby have trouble falling asleep at naptime or at night?

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

16. Does your baby make babbling sounds? For example, does he put sounds together, like “ba-ba-ba-ba” or “na-na-na-na”? (If your child often babbles, mark “most of the time.”)

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

17. Does your baby sleep at least 10 hours in a 24-hour period?



| | | | |
|----------------------------|----------------------------|----------------------------|-----------------------|
| <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 |
|--|---------------------------------------|----------------------------|----------------------------|----------------------------------|
| 18. Does your baby get constipated or have diarrhea? | <input checked="" type="checkbox"/> x | <input type="checkbox"/> v | <input type="checkbox"/> z | <input type="radio"/> |
| 19. Does your baby let you know when she is hungry, hurt, or tired? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> |
| 20. When you talk to your baby, does he turn his head, look, or smile? | <input type="checkbox"/> z | <input type="checkbox"/> v | <input type="checkbox"/> x | <input type="radio"/> |
| 21. Does your baby 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"/> |
| 22. Has anyone expressed concerns about your baby'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"/> |
| _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| 23. Do you have concerns about your baby's eating or sleeping behaviors? If so, please explain: | | | | |
| _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| TOTAL POINTS ON PAGE ____ | | | | |

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

25. What things do you enjoy most about your baby?
