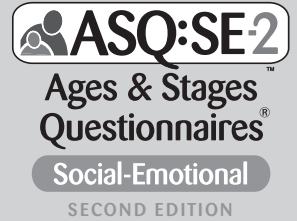




# 24 Month Questionnaire

21 months 0 days to 26 months 30 days (inclusive)



Date ASQ:SE-2 completed: \_\_\_\_\_

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_ Boy  Girl

If born 3 or more weeks prematurely, please indicate the number of weeks premature: \_\_\_\_\_

Date of review with health professional: \_\_\_\_\_

Child's home address: \_\_\_\_\_

\_\_\_\_\_

Town: \_\_\_\_\_ Postcode: \_\_\_\_\_

Person completing the questionnaire: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Home tel: \_\_\_\_\_ Mobile no: \_\_\_\_\_

Email address: \_\_\_\_\_

#### Possible answers:

*Often or always* = your child behaves in this way often or always—it is regular behaviour

*Sometimes* = your child occasionally behaves like this, but not regularly

*Rarely or never* = your child does not behave, or rarely behaves, in this way

# 24 Month QUESTIONNAIRE 21 months 0 days to 26 months 30 days (inclusive)



Questions about the ways in which children may behave are listed on the following pages. Please read each question and tick the box  that best describes your child's behaviour. Also, tick the circle  if the behaviour is of concern to you.

### Important Points to Remember:

- Answer questions based on what you know about your child's behaviour.
- Please bring this questionnaire along with you to your child's health and development review.
- Answer questions based on your child's *usual* behaviour, not behaviour when your child is not feeling well, very tired, or hungry.
- If you have any questions or concerns about your child or this questionnaire, you can ask your health visitor at the review.
- Parents or caregivers should fill in this questionnaire. Caregivers should know the child well and spend more than 15 hours per week with him or her.


	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	TICK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to him?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
3. Does your child laugh or smile when you play with her?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. Is your child's body relaxed?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. When you leave, does your child stay upset and cry for more than an hour?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
6. Does your child greet or say hello to familiar adults?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
7. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
8. 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"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

# 24 Month Questionnaire



Tick the box  that best describes your child's behaviour. Also, tick the circle  if the behaviour is a concern.



	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	TICK IF THIS IS A CONCERN	
9. Does your child stiffen and arch his back when picked up?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
10. 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"/> v	_____
					
11. 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"/> v	_____
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
13. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
<hr/> <hr/>					
14. Does your child 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"/> v	_____
15. 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"/> v	_____
16. Does your child have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
17. Does your child get constipated or have diarrhoea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

# 24 Month Questionnaire



Tick the box  that best describes your child's behaviour. Also, tick the circle  if the behaviour is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	TICK IF THIS IS A CONCERN	
18. Does your child follow simple directions? For example, does she sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
19. Does your child let you know how he is feeling with 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"/> v	_____
20. 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"/> v	_____
21. Does your child do things over and over and get upset when you try to stop her? For example, does she rock, flap her hands, spin, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
22. Does your child like to hear stories or sing songs? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
23. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
24. Does your child like to be around other children? For example, does she move close to or look at other children? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
25. 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"/> v	_____
26. Does your child try to show you things by pointing at them and looking back at you?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

# 24 Month Questionnaire



Tick the box  that best describes your child's behaviour. Also, tick the circle  if the behaviour is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	TICK IF THIS IS A CONCERN	
27. Does your child play with objects by pretending? For example, does your child pretend to talk on the phone, feed a doll, or fly a toy airplane?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Does your child wake three or more times during the night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
29. Does your child respond to his name when you call him? For example, does he turn his head and look at you?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
30. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
31. Has anyone shared concerns about your child's behaviour? If "sometimes" or "often or always," please explain: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

**OVERALL** Use the space below for additional comments.

32. Do you have concerns about your child's eating or sleeping behaviours? If yes, please explain:  YES  NO

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33. Does anything about your child worry you? If yes, please explain:  YES  NO

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34. What do you enjoy about your child?

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