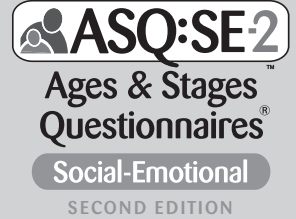




2 Month Questionnaire

1 month 0 days through 2 months 30 days



Date ASQ:SE-2 completed: _____

Baby's information

Baby's first name: _____ Baby's middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks premature, please enter the number of weeks: _____

Baby's gender: Male Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

City: _____ State/province: _____ ZIP/postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Relationship to baby: Parent Guardian Teacher Other: _____
 Grandparent/other relative Foster parent Child care provider

People assisting in questionnaire completion: _____

Program information

(For program use only.)

Baby's ID #:	Age at administration in months and days:
Program ID #:	If premature, adjusted age in months and days:
Program name:	

2 Month Questionnaire 1 month 0 days through 2 months 30 days



Questions about behaviors babies may have are listed on the following pages. Please read each question carefully and check the box that best describes your baby's behavior. Also, check the circle if the behavior is a concern.

Important Points to Remember:

- Answer questions based on what you know about your baby's behavior.
- Answer questions based on your baby's *usual* behavior, not behavior when your baby is sick, very tired, or hungry.
- Caregivers who know the baby well and spend more than 15-20 hours per week with the baby should complete ASQ:SE-2.
- Please return this questionnaire by: _____
- If you have any questions or concerns about your baby or about this questionnaire, contact: _____
- Thank you and please look forward to filling out another ASQ:SE-2 in _____ months.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. When upset, can your baby calm down within a half hour?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your baby like to be picked up and held?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
3. Does your baby stiffen and arch her back when picked up?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
4. When you talk to your baby, does he look at you and seem to listen?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. Does your baby let you know when she is hungry, tired, or uncomfortable? For example, does she fuss or cry?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. When awake, does your baby seem to enjoy watching or listening to people? For example, does he turn his head to look at someone talking?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
7. Is your baby able to calm herself down (for example, by sucking her hand or pacifier)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
8. Does your baby cry for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____




TOTAL POINTS ON PAGE _____

2 Month Questionnaire



Check the box that best describes your child's behavior. Also, check the circle if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Is your baby's body relaxed?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
10. Does your baby have trouble sucking from a breast or bottle?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
11. 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"/> v	_____
12. Do you and your baby enjoy feeding times together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
13. Does your baby have any eating problems, such as gagging, vomiting, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
14. During the day, does your baby stay awake for an hour or longer at one time?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
15. 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"/> v	_____
16. Has anyone shared concerns about your baby's behaviors? 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.

17. Do you have concerns about your baby's eating or sleeping behaviors? If yes, please explain: YES NO

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

19. What do you enjoy about your baby?
