GLEAMNS HEAD START/EHS PROGRAM

CONFIDENTIAL FILE REVIEW SIGN- IN LOG

Child's Name: _____

Date of Birth: _____ **1st Year Enrollment Date:** _____ **2nd Year Enrollment Date:** _____ **3rd Year Enrollment Date:** _____

	Name of Person Reviewing File	Date of Review	Service Area Being Reviewed	Purpose for File Review
1.				
2.				
3.				
4.				
5.				
6.				
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8.				
9.				
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11.				
12.				
13.				
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15.				
16.				
17.				
18.				
19.				
20.				

Because of the confidentiality of children and family records, parents and volunteers are prohibited from viewing records other than those of their own child/family. Therefore, this file is open **"ONLY"** to the appropriate Head Start/Early Head Start Staff and Consultants on a **"NEED TO KNOW BASIS"**. This form must be updated at the start of each school year and as needed.

Updated: 7/2015; 6/2025

GLEAMNS HEAD START / EARLY HEAD START PROGRAM

CLASSROOM FILE EXAMPLE

Screening and Follow Up

(Development & Social Emotional Screening/Results)

ASQ-3 60 Month ASQ-3 Information Summary

57 months 0 days through 66 months 0 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	33.19		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	31.28		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	26.54		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.99		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	39.07		●	●	●	●	●	●	●	●	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1.	Hears well? Comments:	Yes	**NO**	6.	Family history of hearing impairment? Comments:	**YES**	No
2.	Talks like other children his age? Comments:	Yes	**NO**	7.	Concerns about vision? Comments:	**YES**	No
3.	Understand most of what your child says? Comments:	Yes	**NO**	8.	Any medical problems? Comments:	**YES**	No
4.	Others understand most of what your child says? Comments:	Yes	**NO**	9.	Concerns about behavior? Comments:	**YES**	No
5.	Walks, runs, and climbs like other children? Comments:	Yes	**NO**	10.	Other concerns? Comments:	**YES**	No

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101600901

ASQ-3 Ages & Stages Questionnaires®

57 months 0 days through 66 months 0 days

60 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name _____

Child's gender:
◯ Male ◯ Female

Child's date of birth _____

Person filling out questionnaire

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

Relationship to child:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

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

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID # _____

Program ID #: _____

Program name: _____

P101600101

ASQ-3 60 Month Questionnaire

57 months 0 days through 66 months 0 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your giving help by pointing or repeating directions, does your child follow three directions that are *unrelated* to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."	○	○	○	___
2. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:	○	○	○	___
3. When talking about something that already happened, does your child use words that end in "-ed," such as "walked," "jumped," or "played"? Ask your child questions, such as "How did you get to the store?" ("We walked.") "What did you do at your friend's house?" ("We played.") Please write an example:	○	○	○	___
4. Does your child use comparison words, such as "heavier," "stronger," or "shorter"? Ask your child questions, such as "A car is big, but a bus is _____" (bigger); "A cat is heavy, but a man is _____" (heavier); "A TV is small, but a book is _____" (smaller). Please write an example:	○	○	○	___

E101600201

COMMUNICATION (continued)

	YES	SOMETIMES	NOT YET	
Does your child answer the following questions? *(Mark "sometimes" if your child answers only one question.)*	○	○	○	___

"What do you do when you are hungry?" *(Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.")* Please write your child's response:

"What do you do when you are tired?" *(Acceptable answers include: "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.")* Please write your child's response:

6. Does your child repeat the sentences shown below back to you, without any mistakes? *(Read the sentences one at a time. You may repeat each sentence one time. Mark "yes" if your child repeats both sentences without mistakes or "sometimes" if your child repeats one sentence without mistakes.)*	○	○	○	___

Jane hides her shoes for Maria to find.

Al read the blue book under his bed.

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")* 	○	○	○	___
2. Does your child catch a large ball with both hands? *(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)* 	○	○	○	___
3. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? *(You may give your child two or three tries before you mark the answer.)* 	○	○	○	___

GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
Does your child walk on his tiptoes for 15 feet (about the length of a large car)? *(You may show him how to do this.)*	○	○	○	___
5. Does your child hop forward on one foot for a distance of 4–6 feet without putting down the other foot? *(You may give her two tries on each foot. Mark "sometimes" if she can hop on one foot only.)*	○	○	○	___
6. Does your child skip using alternating feet? *(You may show him how to do this.)*	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Ask your child to trace on the line below with a pencil. Does your child trace on the line without going off the line more than two times? *(Mark "sometimes" if your child goes off the line three times.)*	○	○	○	___
2. Ask your child to draw a picture of a person on a blank sheet of paper. You may ask your child, "Draw a picture of a girl or a boy." If your child draws a person with head, body, arms, *and* legs, mark "yes." If your child draws a person with only three parts (head, body, arms, or legs), mark "sometimes." If your child draws a person with two or fewer parts (head, body, arms, or legs), mark "not yet." Be sure to include the sheet of paper with your child's drawing with this questionnaire.	○	○	○	___
3. Draw a line across a piece of paper. Using child-safe scissors, does your child cut the paper in half on a more or less straight line, making the blades go up and down? *(Carefully watch your child's use of scissors for safety reasons.)* 	○	○	○	___
4. Using the shapes below to look at, does your child copy the shapes in the space below without tracing? *(Your child's drawings should look similar to the design of the shapes below, but they may be different in size. Mark "yes" if she copies all three shapes; mark "sometimes" if your child copies two shapes.)*  (Space for child's shapes)	○	○	○	___

E101600401

FINE MOTOR (continued)

	YES	SOMETIMES	NOT YET	
Using the letters below to look at, does your child copy the letters without tracing? Cover up all of the letters except the letter being copied. *(Mark "yes" if your child copies four of the letters and you can read them. Mark "sometimes" if your child copies two or three letters and you can read them.)*	○	○	○	___

V H T C A

(Space for child's letters)

6. Print your child's first name. Can your child copy the letters? The letters may be large, backward, or reversed. *(Mark "sometimes" if your child copies about half of the letters.)*	○	○	○	___

(Space for adult's printing)

(Space for child's printing)

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When asked, "Which circle is smallest?" does your child point to the smallest circle? *(Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)*	○	○	○	___

2. When shown objects and asked, "What color is this?" does your child name five different colors like red, blue, yellow, orange, black, white, or pink? *(Mark "yes" only if your child answers the question correctly using five colors.)*	○	○	○	___

PROBLEM SOLVING (continued)

	YES	SOMETIMES	NOT YET	
3. Does your child count up to 15 without making mistakes? If so, mark "yes." If your child counts to 12 without making mistakes, mark "sometimes."	○	○	○	____
4. Does your child finish the following sentences using a word that means the opposite of the word that is italicized? For example: "A rock is *hard*, and a pillow is *soft*."	○	○	○	____

Please write your child's responses below:

A cow is *big*, and a mouse is ____

Ice is *cold*, and fire is ____

We see stars at *night*, and we see the sun during the ____

When I throw the ball *up*, it comes ____

(Mark "yes" if he finishes three of four sentences correctly. Mark "sometimes" if he finishes two of four sentences correctly.)

5. Does your child know the names of numbers? *(Mark "yes" if she identifies the three numbers below. Mark "sometimes" if she identifies two numbers.)*	○	○	○	____

3 1 2

6. Does your child name at least four letters in her name? Point to the letters and ask, "What letter is this?" *(Point to the letters out of order.)*	○	○	○	____

PROBLEM SOLVING TOTAL ____

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Can your child serve himself, taking food from one container to another, using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?	○	○	○	____
2. Does your child wash her hands and face using soap and water and dry off with a towel without help?	○	○	○	____
3. Does your child tell you at least four of the following? Please mark the items your child knows.	○	○	○	____

- ○ a. First name
- ○ b. Age
- ○ c. City he lives in
- ○ d. Last name
- ○ e. Boy or girl
- ○ f. Telephone number

PERSONAL-SOCIAL (continued)

	YES	SOMETIMES	NOT YET	
4. Does your child dress and undress himself, including buttoning medium-size buttons and zipping front zippers?	○	○	○	___
5. Does your child use the toilet by herself? *(She goes to the bathroom, sits on the toilet, wipes, and flushes.)* Mark "yes" even if she does this after you remind her.	○	○	○	___
6. Does your child usually take turns and share with other children?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other children her age? If no, explain: ○ YES ○ NO

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Can other people understand most of what your child says? If no, explain: ○ YES ○ NO

OVERALL (continued)

5. Do you think your child walks, runs, and climbs like other children his age? If no, explain: ○ YES ○ NO

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

7. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

8. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

9. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

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

60 Month Information Summary *54 months 0 days through 72 months 0 days*

ASQ:SE-2

Child's name: _____ Date ASQ:SE-2 completed: _____

Child's ID #: _____ Child's date of birth: _____

Person who completed ASQ:SE-2: _____ Child's age in months and days: _____

Administering program/provider: _____ Child's gender: ◯ Male ◯ Female

1. ASQ:SE-2 SCORING CHART:

- Score items (*Z* = 0, *V* = 5, *X* = 10, *Concern* = 5).
- Transfer the page totals and add them for the total score.
- Record the child's total score next to the cutoff.

TOTAL POINTS ON PAGE 1	
TOTAL POINTS ON PAGE 2	
TOTAL POINTS ON PAGE 3	
TOTAL POINTS ON PAGE 4	
Total score	

Cutoff	Total score
95	

2. ASQ:SE-2 SCORE INTERPRETATION: Review the approximate location of the child's total score on the scoring graphic. Then, check off the area for the score results below.

____ The child's total score is in the ▭ area. It is below the cutoff. Social-emotional development appears to be on schedule.
____ The child's total score is in the ▭ area. It is close to the cutoff. Review behaviors of concern and monitor.
____ The child's total score is in the ■ area. It is above the cutoff. Further assessment with a professional may be needed.

3. OVERALL RESPONSES AND CONCERNS: Record responses and transfer parent/caregiver comments. YES responses require follow-up.

1–36.	Any Concerns marked on scored items?	YES	no	Comments:
37.	Eating/sleeping/toileting concerns?	YES	no	Comments:
38.	Other worries?	YES	no	Comments:

4. FOLLOW-UP REFERRAL CONSIDERATIONS: Mark all as Yes, No, or Unsure (Y, N, U). See pages 98–103 in the *ASQ:SE-2 User's Guide*.

____ **Setting/time factors** (e.g., Is the child's behavior the same at home as at school?)
____ **Developmental factors** (e.g., Is the child's behavior related to a developmental stage or delay?)
____ **Health factors** (e.g., Is the child's behavior related to health or biological factors?)
____ **Family/cultural factors** (e.g., Is the child's behavior acceptable given the child's cultural or family context? Have there been any stressful events in the child's life recently?)
____ **Parent concerns** (e.g., Did the parent/caregiver express any concerns about the child's behavior?)

5. FOLLOW-UP ACTION: Check all that apply.

____ Provide activities and rescreen in ____ months.
____ Share results with primary health care provider.
____ Provide parent education materials.
____ Provide information about available parenting classes or support groups.
____ Have another caregiver complete ASQ:SE-2. List caregiver here (e.g., grandparent, teacher): _____
____ Administer developmental screening (e.g., ASQ-3).
____ Refer to early intervention/early childhood special education.
____ Refer for social-emotional, behavioral, or mental health evaluation.
____ Other: _____

P201600600

60 Month Questionnaire

54 months 0 days through 72 months 0 days

ASQ-SE-2 Ages & Stages Questionnaires® Social Emotional SECOND EDITION

Date ASQ:SE-2 completed: _____

Child's information

Child's first name _____ Child's middle initial. _____ Child's last name _____

Child's date of birth _____

Child'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 child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Other _____
◯ Grandparent/ other relative ◯ Foster parent ◯ Child care provider _____

People assisting in questionnaire completion: _____

Program information (For program use only.)

Child's ID #: _____ Age at administration in months and days: _____

Program ID #: _____

Program name: _____

P201600000

60 Month Questionnaire *54 months 0 days through 72 months 0 days*

ASQ:SE-2

Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box ☑ that best describes your child'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 child's behavior
- ☐ Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry
- ☐ Caregivers who know the child well and spend more than 15–20 hours per week with the child should complete ASQ:SE-2.
- ☐ Please return this questionnaire by: _____
- ☐ If you have any questions or concerns about your child 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. Does your child look at you when you talk to her?	☐	☐	☐	◯	
2. Does your child cling to you more than you expect?	☐	☐	☐	◯	
3. Does your child like to be hugged or cuddled?	☐	☐	☐	◯	
4. Does your child talk or play with adults he knows well?	☐	☐	☐	◯	
5. When upset, can your child calm down within 15 minutes?	☐	☐	☐	◯	
6. Does your child seem too friendly with strangers?	☐	☐	☐	◯	
7. Does your child settle herself down after exciting activities?	☐	☐	☐	◯	
8. Does your child seem happy?	☐	☐	☐	◯	

TOTAL POINTS ON PAGE _____

60 Month Questionnaire

ASQ:SE-2

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. Does your child cry, scream, or have tantrums for long periods of time?	☐	☐	☐	◯
10. Is your child interested in things around him, such as people, toys, and foods? 	☐	☐	☐	◯
11. Does your child go to the bathroom by herself? (Reminders and help with wiping are okay.)	☐	☐	☐	◯
12. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	☐	☐	☐	◯
13. Does your child stay with activities she enjoys for at least 15 minutes (other than watching shows or videos, or playing with electronics)?	☐	☐	☐	◯
14. Do you and your child enjoy mealtimes together?	☐	☐	☐	◯
15. Does your child do what you ask him to do? For example, does he wash his hands or wait to take a turn when asked?	☐	☐	☐	◯
16. Does your child seem more active than other children her age?	☐	☐	☐	◯
17. Does your child sleep at least 8 hours in a 24-hour period?	☐	☐	☐	◯
18. Does your child use words to tell you what he wants or needs?	☐	☐	☐	◯

TOTAL SCORE: (GO BACK)

60 Month Questionnaire

ASQ:SE-2

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

	OFTEN OR ALWAYS	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
19. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad?"	☐	☐	☐	◎
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	☐	☐	☐	◎
21. Does your child explore new places, such as a park or a friend's home?	☐	☐	☐	◎
22. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or _____? (Please describe.) _____ _____	☐	☐	☐	◎
23. Does your child hurt herself on purpose?	☐	☐	☐	◎
24. Does your child follow rules at home or at child care?	☐	☐	☐	◎
25. Does your child destroy or damage things on purpose?	☐	☐	☐	◎
26. Does your child stay away from dangerous things, such as fire and moving cars?	☐	☐	☐	◎
27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?	☐	☐	☐	◎
28. Do *other* children like to play with your child? 	☐	☐	☐	◎

TOTAL POINTS ON PAGE _____

60 Month Questionnaire

ASQ:SE-2

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
29. Does *your child* like to play with other children?	☐	☐	☐	◎
30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐	☐	☐	◎
31. Does your child take turns and share when playing with other children?	☐	☐	☐	◎
32. Does your child show an unusual interest in or knowledge of sexual language and activity?	☐	☐	☐	◎
33. Does your child wake three or more times during the night?	☐	☐	☐	◎
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	☐	☐	☐	◎
35. Does your child have simple back-and-forth conversations with you? For example: Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	☐	☐	☐	◎
36. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	☐	☐	☐	◎

OVERALL Use the space below for additional comments

37. Do you have concerns about your child's eating, sleeping, or toileting habits? If yes, please explain: ◯ YES ◯ NO

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

39. What do you enjoy about your child?

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

ASQ:SE™

36 Month/3 Year Questionnaire

(For children ages 33 through 41 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.

ASQ:SE™

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

36 Month/3 Year ASQ:SE Questionnaire

(For children ages 33 through 41 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: _____

ASQ:SE™

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 her?	☐ z	☐ v	☐ x	○
2. Does your child like to be hugged or cuddled?	☐ z	☐ v	☐ x	○
3. Does your child talk and/or play with adults he knows well?	☐ z	☐ v	☐ x	○
4. Does your child cling to you more than you expect?	☐ x	☐ v	☐ z	○
5. When upset, can your child calm down within 15 minutes?	☐ z	☐ v	☐ x	○
6. Does your child seem too friendly with strangers?	☐ x	☐ v	☐ z	○
7. Can your child settle herself down after periods of exciting activity?	☐ z	☐ v	☐ x	○
8. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	☐ z	☐ v	☐ x	○
9. Does your child seem happy?	☐ z	☐ v	☐ x	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around him, such as people, toys, and foods?	☐ z	☐ v	☐ x	○
11. Does your child do what you ask her to do?	☐ z	☐ v	☐ x	○
12. Does your child seem more active than other children her age? 	☐ x	☐ v	☐ z	○
13. Can your child stay with activities she enjoys for at least 5 minutes (not including watching television)?	☐ z	☐ v	☐ x	○
14. Do you and your child enjoy mealtimes together?	☐ z	☐ v	☐ x	○
15. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	☐ x	☐ v	☐ z	○
16. Does your child sleep at least 8 hours in a 24-hour period?	☐ z	☐ v	☐ x	○
17. Does your child use words to tell you what he wants or needs?	☐ z	☐ v	☐ x	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child follow routine directions? For example, does she come to the table or help clean up her toys when asked?	☐ z	☐ v	☐ x	○
19. Does your child cry, scream, or have tantrums for long periods of time? 	☐ x	☐ v	☐ z	○
20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home? 	☐ z	☐ v	☐ x	○
21. 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	○
22. Does your child hurt himself on purpose?	☐ x	☐ v	☐ z	○
23. Does your child stay away from dangerous things, such as fire and moving cars?	☐ z	☐ v	☐ x	○
24. Does your child destroy or damage things on purpose? 	☐ x	☐ v	☐ z	○
25. Does your child use words to describe her feelings and the feelings of others, such as, "I'm happy," "I don't like that," or "She's sad"?	☐ z	☐ v	☐ x	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
26. Can your child name a friend?	☐ z	☐ v	☐ x	○
27. Do *other* children like to play with your child?	☐ z	☐ v	☐ x	○
28. Does *your child* like to play with other children?	☐ z	☐ v	☐ x	○
29. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	○
30. Does your child show an interest in or knowledge of adult sexual language and activity?	☐ x	☐ v	☐ z	○
31. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	☐ x	☐ v	☐ z	○

_____

_____

_____

_____

32. Do you have any concerns about your child's eating, sleeping, or toileting habits? If so, please explain:

_____

_____

_____

_____

TOTAL POINTS ON PAGE ___

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

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

36 Month/3 Year ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____

erson filling out the ASQ:SE: _____ Relationship to child: _____

Mailing address: _____

Telephone: _____ City: _____ State: _____ ZIP: _____

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 40 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 40–42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Total points on page 6	= _____
Child's total score	= _____

SCORE INTERPRETATION

Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

2. *Transfer child's total score*

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
36 months/3 years	59	

3. *Referral criteria*

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

4. *Referral considerations*

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 45–50 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors
  (e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors
  (e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors
  (e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors
  (e.g., Is the child's behavior acceptable given cultural or family context?)

Family Assessment

(Family Goals, Parent Assessment)

Family Goals Document

Parent Assessment

Date Submitted: 07/20/2026
Date Reviewed: 07/21/2026

Parent Orientation Toward Preschool and Child Rearing

Please explain reason(s) you enrolled your child in our Program.: I enrolled my child in early head start to give him a jump start on school even though it starts at home it's still better for him to know more as far as sitting down being in class setting learning the in and out.
Please check if you think your child should learn the following.: How to work together.
Name at least three places you usually take your child with you.: Grocery store shopping vacation
Name one place you usually take your child to have a nice time and learn.: Home
Would you like to work with children in the classroom?: No
If yes, what would you prefer doing in the classroom?: N/A
Please check if you would like to know more about any of the following.: Whether my child is developing appropriately., How to prepare my child for success in school.
What is your opinion about Head Start/Early Head Start parents coming together at least once a month to talk about and learn more about areas in which you answered YES above.: I think it's a great opportunity for parents.
How can we make sure the meetings are engaging and meaningful?: Just by engaging with the parents.
Would you be willing to help organize a parent meeting?: Yes
Are there other ways you would be willing to help make the meetings more successful?: No
Name a special talent you have or information you would be willing to share with other parents.: N/A

Digital signature

Parent name: [redacted]
Date: 07/20/2026
Parent signature: 

Home Visits

GLEAMNS Initial Home Visit Form, 2023

This form will be used to document the inital home visit.

Child's Name *

Center *

Child Enrolled In *

Home Visit Conducted? *

Phone

Date of Home Visit *

Time of Home Visit *

AM/PM *

Please list all adults participating in the home visit, including teacher and teacher assistant or substitute teacher.

Adult Participants

	Name	Relationship to Child
⊗		

+ Add Item

Is Head Start or Early Head Start child present during the visit?

- (•) Yes
- ( ) No

Ask child and parent to share the following:

What does your child enjoy doing in his/her free time? *

What are your hopes for your child during this school year? *

What are some important events your family might celebrate? *

What are your concerns about your child's development? *

STAFF CERTIFICATION

I certify I have completed this virtual home visit with the parent. If this form has been falsified, I understand my employment in this Program may be terminated. I also understand the electronic signature replaces a handwritten signature for the purpose of this form.

Electronic Signature of Staff *

Date of Signature *

Staff Position *

Email *

Save

GLEAMNS Second Home Visit Form, 2024

This form will be used to document the child's second home visit.

Child's Name *

Center *

Child Enrolled In *

Home Visit Conducted? *

Phone

Date of Home Visit *

Time of Home Visit *

AM/PM *

Please list all adults participating in the home visit:

Adult Participants

Name	Relationship to Child

+ Add Item

Is Head Start or Early Head Start child present during the visit?

(•) Yes ( ) No

Ask parent to share the following:

What are your child's favorite play activities? *

What are some ways you promote literacy at home? (Example: reading to your child each day, asking questions about a book, talking with your child about things that happened, etc.) *

What are some ways you help your child with his or her learning or development at home? *

Teacher input:

Teacher will share one tip or strategy to support child's growth and development.

STAFF CERTIFICATION

I certify I have completed this virtual home visit with the parent. If this form has been falsified, I understand my employment in this Program may be terminated. I also understand the electronic signature replaces a handwritten signature for the purpose of this form.

Electronic Signature of Staff *

Date of Signature *

Staff Position *

Email *

Submit

Save

Parent Teacher Conference

GLEAMNS First Parent-Teacher Conference Form - SY 2023-2024

This form will be used by teachers to document their parent-teacher conferences. Please give a copy of the completed form to the Center Coordinator to place in child's comprehensive file.

Child's Name *

Center *

Child Enrolled In *

Date of Conference *

Time of Conference *

AM/PM *

Conference Conducted? *

Name of Family Member Completing Conference *

Please use this field to identify the parent or family member who is providing responses during the conference.

Relationship to Child *

Phone

Teacher Feedback: Please discuss the child's TSG Child Development and Learning Report, ChildPlus attendance report, and ChildPlus health summary.

From your observation and ongoing assessment, share one positive thing you have observed about the child. *

From your observation and ongoing assessment, share one area where the child can improve. *

Parent or Guardian Feedback (ask parents to share thoughts on following questions)

What areas of progress have you seen in your child since the start of school? *

What concerns do you have about your child's progress? *

What do you need from the teaching staff for your child to be successful? *

What concerns do you have about your child transitioning to their next educational setting? *

STAFF CERTIFICATION

I certify I have completed this virtual parent-teacher conference with the parent. If this form has been falsified, I understand my employment in this Program may be terminated. I also understand the electronic signature replaces a handwritten signature for the purpose of this form.

Electronic Signature of Staff * **Date of Signature** * **Staff Position** *

Email *

Submit Save

GLEAMNS Second Parent-Teacher Conference Form - SY 2023-2024

This form will be used by teachers to document their parent-teacher conferences. Please give a copy of the completed form to the Center Coordinator to place in child's comprehensive file.

Child's Name *

Center *

Child Enrolled In *

Date of Conference *

Time of Conference *

AM/PM *

Conference Conducted? *

Name of Family Member Completing Conference *

Relationship to Child *

Phone

Please use this field to identify the parent or family member who is providing responses during the conference.

Teacher Feedback: Please discuss the child's TSG Child Development and Learning Report, ChildPlus attendance report, and ChildPlus health summary.

From your observation and ongoing assessment, share one positive thing you have observed about the child. *

From your observation and ongoing assessment, share one area where the child can improve. *

Parent or Guardian Feedback (ask parents to share thoughts on following questions)

What areas of progress have you seen in your child since the start of school? *

What concerns do you have about your child's progress? *

What do you need from the teaching staff for your child to be successful? *

What concerns do you have about your child transitioning to their next educational setting? *

STAFF CERTIFICATION

I certify I have completed this virtual parent-teacher conference with the parent. If this form has been falsified, I understand my employment in this Program may be terminated. I also understand the electronic signature replaces a handwritten signature for the purpose of this form.

Electronic Signature of Staff *

Date of Signature *

Staff Position *

Email *

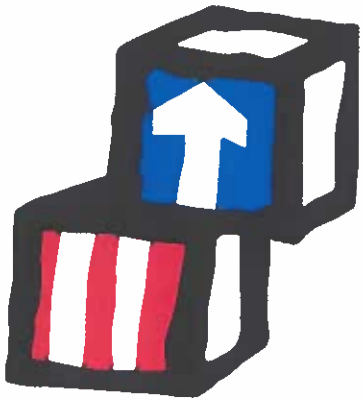
Submit

Save

Teaching Strategies Gold

Other Pertinent Information

(Social Emotional Development Questionnaire, IEP/IFSP)



Social-Emotional Development

Date Submitted: 07/20/2026
Date Reviewed: 07/21/2026

Social-Emotional Development

Does your child take a nap?: Yes
What is the length of your child's typical nap?: At least 60 minutes
Does your child get eight or more hours of sleep each night.: Yes
If no, what prevents your child from getting at least eight hours of sleep a night?:
How does your child act with adults he or she does not know? For example, shy, withdrawn, friendly, etc.: Friendly
How does your child act with a few children his/her own age? For example, plays well, fights, prefers playing alone, etc.: Plays well
Have there been any big changes in your child's life in the last six months?: No
If yes, please explain.:
Do you have any concerns about your child's development?: No
If yes, please explain:
How long has your child's behavior been a concern?:
Does your child have any difficulties saying what he/she wants to do?: No
If yes. please explain further.:
Does your child's temper change for no apparent reason?: No
If yes. please explain further:
Does your child often say he/she does not like you when you discipline him/her?: No
Does your child kick, scream, or have tantrums when angry?: No
If yes, how long does the behavior last?:
How do you manage your child's behavior?: Discipline