



Child's Name: \_\_\_\_\_

Does your child have a nickname?  Yes  No

If yes, what is it: \_\_\_\_\_

**Family**

Names of brothers & sisters

Birthdate

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Names of others living in the home

Relationship to child

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

What language is spoken in your home: \_\_\_\_\_

Does your child have pets?  Yes  No

If yes, what are they \_\_\_\_\_

**Food**

Is your child breast-fed?  Yes  No

If yes:

Do you plan to continue breast feeding?  Yes  No

If yes, how do you plan to carry this out? \_\_\_\_\_

What is your child's feeding schedule? \_\_\_\_\_

Do you supplement? \_\_\_\_\_

Is your child bottle-fed?  Yes  No

If yes: What is your child's bottle feeding schedule?

Liquids	Type	Amount	Times
Formula			
Milk			
Water			

What position does your child like to be in while bottle feeding? \_\_\_\_\_

What position does your child like to be in while being burped? \_\_\_\_\_

Has your child been introduced to solids?  Yes  No

If yes, what type?  baby food  table food

What is your child's feeding schedule:

<b>Solids</b>	<b>Type</b>	<b>Consistency</b>	<b>Amount</b>	<b>Times</b>
<b>Cereal</b>				
<b>Cereal</b>				
<b>Cereal</b>				
<b>Vegetable</b>				
<b>Vegetable</b>				
<b>Vegetable</b>				
<b>Vegetable</b>				
<b>Fruit</b>				
<b>Fruit</b>				
<b>Fruit</b>				
<b>Fruit</b>				
<b>Meat</b>				
<b>Meat</b>				
<b>Snack</b>				
<b>Snack</b>				

Does your child have any food sensitivities?  Yes  No

If yes, please identify: \_\_\_\_\_

What foods does your child like/dislike? \_\_\_\_\_

### **Sleep**

Describe your child's sleep routine (include naps & lengths of naps):

\_\_\_\_\_

Does your child usually cry when going to sleep?  Yes  No

If yes, for how long? \_\_\_\_\_

Where does your child normally sleep? \_\_\_\_\_

**Diapering**

What type of diapers does your child use? \_\_\_\_\_

Describe your child’s diapering routine (include double diapering, liners, creams, powders etc.) \_\_\_\_\_

Is your child prone to diaper rash?  Yes  No Treatment: \_\_\_\_\_

**Social/Emotional Development**

Describe your child’s temperament: (i.e. colic, likes to cuddle)

\_\_\_\_\_

What signs does your child give of being hungry, tired or overstimulated? (i.e. pulls at ears, rubs eyes) \_\_\_\_\_

Does your child separate easily from you?  Yes  No

Please comment: \_\_\_\_\_

Is your child afraid of anything?  Yes  No

Please comment: \_\_\_\_\_

Does your child have a favorite toy, blanket or soother?  Yes  No

Please identify: \_\_\_\_\_

Does your child spend time with other children?  Yes  No

Please comment: (who, when, how much) \_\_\_\_\_

What activities does your child enjoy? \_\_\_\_\_

Please provide any other information relating to your child that would be helpful in understanding and caring for your child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_  
D M Y

\_\_\_\_\_  
Parent/Guardian signature