



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? \_\_\_\_\_

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			



Does your child have any food sensitivities?  Yes  No  
If yes, please identify: \_\_\_\_\_

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

Table foods (please specify if limited) \_\_\_\_\_

### **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? \_\_\_\_\_

Rest time/s \_\_\_\_\_

What does he/she take to bed (blanket, bottle, pacifier, etc.) \_\_\_\_\_

What is his/her mood upon  
awakening? \_\_\_\_\_

### **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 over stimulated?  
(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? \_\_\_\_\_  
\_\_\_\_\_

**Miscellaneous:**

Does child have an "unsettled" time? \_\_\_\_\_  
When? \_\_\_\_\_

How does child relate to strangers?  
\_\_\_\_\_

What if anything do you do for teething? \_\_\_\_\_

Do you allow the baby to have a pacifier?: Yes, No  
If so when? just at bedtime, just when fussy, anytime

Are any medications given regularly?  
\_\_\_\_\_

What time does the baby awaken?  
\_\_\_\_\_

What time does your baby go to sleep at night?  
\_\_\_\_\_

Does he/she sleep through the night? Yes, No

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

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

Daily Schedule:

7:00

7:30

8:00

8:30

9:00

9:30

10:00

10:30

11:00

11:30

12:00

12:30

1:00

1:30

2:00

2:30

3:00

3:30

4:00

4:30

5:00

5:30

6:00

Date:   /  /    
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\_\_\_\_\_

Parent/Guardian signature

