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:

Solids	Type	Consistency	Amount	Times
Cereal				
Cereal				
Cereal				
Vegetable				
Vegetable				
Vegetable				
Vegetable				
Fruit				
Fruit				
Fruit				
Fruit				
Meat				
Meat				
Snack				
Snack				

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