Infant 1 & 2 All About Me

Child's name: _____ Date of Birth: _____

Date Form was completed: _____

Liquids:

1. Is your child being fed: ____Breast Milk____ Formula
   If formula, what brand? _____
2. How much milk/ formula is offered at each feeding? _____
   How often is your child being fed? _____
3. After how many ounces should your child be burped? _____
4. Does your child spit up after bottles? _____
5. Does your child's bottle need to be warmed up? _____
6. What does your child do if your child appears hungry between feedings?
   _____
   _____
7. How does your child act when they are hungry?
   _____
   _____
8. Is there any more information you feel that we need to know about your child feedings?
   _____
   _____

Developmental History:

1. Has your child?
   _____ Held his/her head up
   _____ Rolled over
   If so:
   _____ front to back
   _____ Back to front

   _____ reached for objects

   _____ smiled
2. Is your child cooing/ gurgling? _____ Yes _____ No
3. Do you think your child teething? _____ Yes _____ No _____
4. How many teeth does your child have? _____

Toilet Habits:

1. How many bowel movements does your child have a day? _____
   Consistency? _____ Solid _____ Soft _____ Very Soft
   Is there anything that causes diarrhea for your child?
   _____
2. Has your child ever been constipated? _____ Yes _____ No
   If yes, what was the cause and treatment?
   _____
   _____

3. Have diapers rashes been a problem? _____ yes _____ No
   If yes, how did you treat?

_____
_____

4. Do you use disposable or cloth diapers? _____ If cloth, how do you want them stored when soiled? _____

Sleeping Habits:

1. Does your child have trouble sleeping at night? _____ Yes _____ No
2. Does your child sleep in a crib? _____ Yes _____ No
3. Does your child sleep with anything special at home? If yes, please list.

   _____
   _____

4. Does your child have any special sleep routines?
   _____ Rocked __ Blanket _____ Book _____Music _____ Toy _____ Other
   Please describe:

   _____
   _____

5. How does your child wake up? _____ Happy _____ Grumpy
6. How many naps does your child take during the day? _____ Approx length _____
7. How long does your child nap?

   _____
   _____

Other:

1. Do you foresee any problems in regard to placing your child in daycare?

   _____
   _____

2. How could we make your child's transition into care easier?

   _____
   _____

3. Does your child have any other health concerns that we should know about? (i.e., Acid reflux, torticollis, etc.)

   _____
   _____

4. Do you have any additional comments or suggestion?

   _____
   _____

Solids:

1. Does your child eat baby food? _____ or adult food? _____
2. How often do they eat?

   _____
   _____