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 you child spit up after bottles?____
5 Does your child's bottle need to be warmed up?______________________________
6 What do you 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 should know about your child's 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 is 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 can cause diarrhea for your child?
____
2 Has your child ever been constipated? _____ Yes _____ No
If yes, what was the cause and treatment?
____

____

3 Have diaper rashes been a problem? _____ Yes _____ No
If yes, how did you treat?
____
____

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 descibe:
____
____
5 How does your child wake up? _____ Happy _____Grumpy
6 How many naps does your child take during the day? _________________________
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 our care easier?
____
____
3 Does your child have any health concerns that we should know about?
____
____
4 Do you have any additional comments or suggestions?
____
____

Solids:

1 Does you child eat baby food? ___________ or adult food?________

2 How often do they eat? ____
____