Personal Information Record for Infants/Toddlers

Child’s Name: ___________________________ Age: ________

1. What is your child’s current daily sleeping schedule?
   Morning Wake-up Time: _______ Evening Bedtime: ________________
   Daily Naps: ________________________________

2. Is your child sleeping through the night? ________________________
   If not, when does child usually wake up at night? ________________

3. What upsets or frightens your child? ________________________________

4. What does your child find soothing or comfortable? _______________________

5. How is your child now reacting to strangers? _________________________

6. Is your child using a cup, a bottle or both? _______________________

7. Are you breast feeding you child? Yes No
   If yes, at what times? _______________________________

8. What are the times your child is receiving the bottle each day? _______

9. Give the number of ounces your child is now taking at each bottle feeding?
   _______________________________

10. Is your child taking formula, whole milk, skim milk or other? _________

11. Give any special instructions for preparing formula, if any? __________

12. Are there any other special instructions concerning bottle feeding you child?
   _______________________________

13. Is your child now on baby food or table food? ______________________

14. List foods your child is now eating:
   Vegetables       Fruits       Meats       Juices       Breads
15. Is your child now eating finger foods?  Yes  No  
If yes, please list: 

16. Where does your child spend her/his waking hours?  

17. What toys and activities make her/him happy?  

18. When does your child usually have bowel movements?  

19. Has your child begun potty training?  Yes  No  
If yes, describe her/his routine: 

20. What does your child call her/his:  
Bowel Movement:  Urination:  

21. This space is for any other information you wish to share about your child: 

Parents Signature:  Date:  
Providers Signature:  Date:  