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: _____