

Infant Developmental History



Child's Name: _____ DOB: _____
 Parent's Names: _____

Sleeping:

- Please fill in typical sleeping patterns:

Nighttime:		to	
AM Nap:		to	
PM Nap:		to	

- Preferred Sleeping Position:
 - Back
 - Other (Back sleeping is the recommended position. Your baby's doctor must give written orders if we are to use another position or crib device.)

Feeding:

- Baby Drinks:
 - Breast milk
 - Formula (Type: _____)
 - Whole Milk
 - Other: _____
- Baby Uses:
 - Bottle
 - Sippy Cup
- Baby Prefers Bottles:
 - Warm
 - Room Temperature
 - Cold
- Baby is fed every _____ hours.
- Baby's typical feeding times and amounts (include foods and liquids):
 - Breakfast: _____
 - Lunch: _____
 - Snacks: _____
- Check snack/breakfast items that we may serve your child at the center:
 - None Apply
 - Crackers (ex: graham, saltine, cheese)
 - Cheerios or similar cereals
 - Mum Mums/Puffs
 - Yogurt Melts
 - Canned fruit
 - Cheese
 - Pancakes, waffles, French toast, etc.
- Any food restrictions?

Health:

- Is your baby generally healthy? _____
- Describe any health issues:
 - Reflux _____
 - Clogged tear ducts _____
 - Eczema _____
 - Allergies _____
 - Other _____

- Please let us know about any ongoing medications that your child is taking:

Diapering:

- How frequent are bowel movements? _____
- Describe the normal appearance of bowel movement:

- Is your baby prone to diaper rashes? ____ Yes ____ No
 If yes, what is the best treatment to use? _____

Getting Acquainted:

- Share with us the best ways to comfort your child:

- List favorite toys and activities:

- Does your baby use a pacifier?
 - Yes
 - No
- Other information about your baby:

REQUIRED MONTHLY:

My signature below indicates that this form has been checked and updated:

Month:	Date:	Signature:
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		