Infant and Toddler History

(6 weeks to 23 months)

Child's Name_____

Birthdate_____ Today's Date_____

Health

Does this child seem well most of the time? Yes No

Is this child taking any medicines now, including aspirin, laxatives, or vitamins? Yes No

Are you concerned about your child's hearing? Yes No

Are you concerned about your child's eyes or vision? Yes No

What arrangements have you made for the care of your child should he or she becomes ill at the Center?_____

Does your child have any disabilities? Yes No

Please describe:_____

List any other illnesses or diseases:_____

Has this child been hospitalized? Yes No

Please describe:_____

Has this child had any serious accidents or poisonings? Yes No

Please describe:_____

Has your child had any of the following: Premature birth, birth injury, birth defect, convulsions, seizures, asthma, or head injury? Yes No

Please describe:_____

Does your child have any birthmarks? Yes No

Please describe:_____

Developmental History

How do you comfort your child?_____

What are your child's favorite toys?_____

What are your child's favorite activities?_____

Does your child roll over stomach to back? Yes No

Back to stomach? Yes No

Does your child sit with support? Yes No

Sit without support? Yes No

Does your child pull up? Yes No

Does your child crawl? Yes No

Does your child walk with support? Yes No

Continued on the back….

Sleeping

Do you have any special ways of getting your child to sleep?_____

_____

What is your child's present sleeping schedule?

Morning Nap_____

Afternoon Nap_____

Night Time_____

Does your baby use a pacifier? Yes No

Does your child suck his thumb? Yes No

Does your child need a specific toy? Yes No

Feeding

Is your baby breastfed? Yes No

Is your baby bottle fed? Yes No

What type of formula do you use?_____

What type of water do you mix it with?_____

What type of bottle do you use?_____

How often does your baby eat?_____

Please list your child's present eating schedule of Milk, Juice, and Foods:

Breakfast_____

Lunch_____

Snack_____

Dinner_____

Does your child have any feeding problems? Yes No

Please describe:_____

Is your child fed while being held, infant seat, or high chair?_____

Does your child have colic and how do you remedy the situation? _____

_____

Toileting

How frequently does your child have a bowel movement?_____

Does your child have diarrhea and how do you remedy the situation?_____

_____

Does your child become constipated and how do you remedy the situation?_____

_____

Does your child frequently have diaper rash and how do you treat it?_____

_____

Is your baby's skin highly sensitive to anything?_____