



Infant Personal Information Sheet

Child's Name _____ Birthdate _____

1. What is your child's current daily sleeping schedule?

Morning wake-up _____ Daily Naps _____ Evening Bedtime _____

2. How do you put your child down for a nap? (rocking, swing, lie in crib etc.) _____

3. Is your child sleeping through the night? _____
If not, when does your child usually wake up at night? _____

4. What upsets or frightens your child? _____

5. What does your child find soothing or comforting? _____

6. How is your child now reacting to strangers? _____

7. Is your child using a cup, a bottle or both? _____

8. Are you breast-feeding? _____ If yes, what times? _____

9. What are the times your child is now receiving the bottle each day and how many ounces at each feeding? _____

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

11. Give any special instructions for preparing formula/foods. _____

12. Are there any other special instructions concerning bottle-feeding your child? _____

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

14. Does your child use a pacifier when he/she sleeps? _____ Yes _____ No

15. Do you give permission for your child to have their pacifier at naptime? _____ Yes _____ No

16. List foods your child is now eating:

Fruits	Veggies	Meats	Starches

17. List any other foods your child is now eating (snack foods). _____

18. Where does your child spend his/her waking hours? (Swing, Exersaucer, bouncy seat, crawling, etc.)

19. What toys and activities make him/her happy? _____

20. Names of brothers, sisters, or anyone that lives with you. _____

21. Please use this space for any other information you wish to share about your child.

Parent Signature _____ Date _____