Child Intake From

Childs Full Name____________________________________ Nickname_______________

Birthdate____________________

HEALTH

Child has frequent: (please circle all that apply)

Colds Ear Infections Colic Sensitive Stomach Other:___________________

____

____

____

UPDATES:

MEALS

Current Feeding Schedule:

Food Type: Formula Breast Milk Table Food Other:_________________

Special Feeding Problems:_________________________________

Feeds Self: Yes No

Food Allergies:____

Favorite Foods____

____

Refused Foods____

____

Special Feeding Instructions____

____

____

____

UPDATES

SLEEP

Current Sleep Schedule:

Sleep Position- child under age 1 year

Note: Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is on file.

Back   Side or Stomach

Sleep Position- child over age 1 year

Back   Side   Stomach

UPDATES

DIAPERING/TOILETING

Diaper Type: Cloth Disposable Pull Up

Highly Sensitive Skin: Yes No

Frequent Diaper Rash: Yes No

Lotions, Powders, or Salves Used? Yes No

If "Yes" specify product____

Toilet Training Attempted? Yes No

Regular Bowel Movements? Yes No

How Often:____ ________________________ Time of Day:_____________________________

Diapering or Toileting Problems:____

____

____

UPDATES

COMFORTING

Does your child have a fussy time of day? Yes No If "yes" specify time:

My child likes to be:

Held Sung to Rocked Read to Other______________

Special things you say or do to comfort your child____________________________________

____

____

UPDATE

SELF EXPRESSION

What causes your child to feel angry or frustrated?____

____

____

What frightens your child?____

____

____

Additional comments?____

____

____

UPDATES

PHYISCAL AND SOCIAL DEVELOPMENT

Is your child able to (circle all that apply)

Sit up alone   Pull up   Walk holding on   Walk without support

Is your child used to being around other children?   Yes   No

UPDATES

Additional Comments____

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