



**INFANT FACT SHEET**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Primary Contact's Name \_\_\_\_\_

**HEALTH**

Does your child seem well most of the time? Yes \_\_\_ No (explain) \_\_\_\_\_

Does your child take any regular medications, vitamins, or laxatives? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Are you concerned about your child's vision? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have any disabilities? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child had any of the following:

premature birth Yes \_\_\_\_\_ No \_\_\_\_\_

birth injury Yes \_\_\_\_\_ No \_\_\_\_\_

birth defects Yes \_\_\_\_\_ No \_\_\_\_\_

convulsions Yes \_\_\_\_\_ No \_\_\_\_\_

seizures Yes \_\_\_\_\_ No \_\_\_\_\_

asthma Yes \_\_\_\_\_ No \_\_\_\_\_

head injury Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have colic? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how do you treat it? \_\_\_\_\_

Is your child's skin highly sensitive to anything? \_\_\_\_\_

Are there any other significant illnesses that we need to know about? \_\_\_\_\_

What arrangements have you made for the care of your child should he become ill at the center?  
\_\_\_\_\_

**DEVELOPMENT HISTORY**

How do you comfort your child? \_\_\_\_\_

What are your child's favorite toys? \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

Does your child use a pacifier? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child suck his thumb? Yes \_\_\_\_\_ No \_\_\_\_\_

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 crawl? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child pull up to furniture? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child stand without support? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child walk without support? Yes \_\_\_\_\_ No \_\_\_\_\_

SLEEPING

Do you have any special ways of helping your child get to sleep? \_\_\_\_\_

What is your child's present sleeping schedule?

Morning Nap from \_\_\_\_\_ to \_\_\_\_\_

Afternoon Nap from \_\_\_\_\_ to \_\_\_\_\_

Night Time from \_\_\_\_\_ to \_\_\_\_\_

FEEDING

Is your child breastfed? Yes \_\_\_\_\_ No \_\_\_\_\_

If breastfed, does your child also take a bottle? Yes \_\_\_\_\_ No \_\_\_\_\_

Is your child formula fed? Yes \_\_\_\_\_ No \_\_\_\_\_

What type of formula do you use? \_\_\_\_\_

What type of bottle do you use? \_\_\_\_\_

How many ounces does your child typically consume at one feeding? \_\_\_\_\_

How many ounces does your child eat before he/ she needs to burp? \_\_\_\_\_

Has baby food or cereal been introduced? Yes \_\_\_\_\_ No \_\_\_\_\_

If so what kind? \_\_\_\_\_

Please describe your child's present eating schedule and typical foods offered:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Snacks \_\_\_\_\_

Dinner \_\_\_\_\_

Does your child handle a cup or spoon? \_\_\_\_\_

Does your child eat in a high chair? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child eat at a table? Yes \_\_\_\_\_ No \_\_\_\_\_

Are there any other significant feeding issues that we need to know about? \_\_\_\_\_

TOILETING

How frequently does your child have a bowel movement? \_\_\_\_\_

What time of the day? \_\_\_\_\_

Is diarrhea \_\_\_\_\_ or constipation \_\_\_\_\_ a problem?

If so, how do you treat it? \_\_\_\_\_

Is diaper rash a problem? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how do you treat it? \_\_\_\_\_

Are there any other facts that we should know about your child? \_\_\_\_\_