Infant Supplemental Information

Child’s Name_________________________________Age_____________Date____-____-____

Eating Patterns:

Feeding Schedule: ____________________________

How is child fed?  __Lap__High chair__Infant seat__Other__________

________Uses bottles__Breast fed__Cup

Drinks: __Formula__Breast milk__Juice

Eats: __Baby food__Table food__Both

What can your child NOT have based on physician’s statement: ________________________________

Any food allergies or special needs? [ ] YES [ ] NO What? _________________________________

*A physician’s statement must be brought in for any foods your child can not have or any special needs or requirements.

Any history of colic? [ ] YES [ ] NO

Napping Patterns:

What time does your baby usually require a nap? ______, ______, ______, ______

Typically sleeps in: [ ] Crib[ ] Bed[ ] Swing

How do you help your baby fall asleep? __________________________________________

What kind of mood is he/she normally in upon awakening? __________________________

Diaper Needs:

What size diaper does your baby wear now: 1 2 3 4 5 6 (circle one)

Do you use: __Desitin__A&D Ointment

Does your baby have a problem with diaper rash? [ ] YES [ ] NO

If so, how do you treat it? _________________________________

Miscellaneous:

Does your baby have an “unsettled” time? [ ] YES [ ] NO When? ____________

What do you do to help him or her? __________________________________________

How does your child relate to strangers? _________________________________

What do you do for teething? ___________________________________________