

*In an effort to help your child adjust to our program and to serve you better, please take a few moments to answer the following questions. Thank you.*

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

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

Morning wake-up time \_\_\_\_\_ Daily naps \_\_\_\_\_ Evening bedtime \_\_\_\_\_

2. What upsets or frightens your child? \_\_\_\_\_

3. What does your child find soothing or comfortable? \_\_\_\_\_

4. Is your child using a cup, bottle or both? \_\_\_\_\_

5. Are you breastfeeding your child?  Yes  No If yes, at what times? \_\_\_\_\_

6. At what time does your child receive each liquid feeding? \_\_\_\_\_

7. What is the number of ounces your child is taking in each bottle? \_\_\_\_\_

8. Is your child taking formula, whole milk, skim milk, or other? \_\_\_\_\_

9. Are there any special instructions for preparing your child's formula? If yes, please explain. \_\_\_\_\_

10. Does your child like his/her milk/formula?  Very Warm  Room Temperature  Warm  Cold

11. Are there any other special instructions concerning bottle feeding of your child? \_\_\_\_\_

12. Is your child now taking baby food or table food? \_\_\_\_\_

13. List the foods your child is currently eating:

<u>Vegetables:</u>	<u>Fruits:</u>	<u>Meats:</u>	<u>Juices:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. What food should not be given to your child? \_\_\_\_\_

15. Has your child begun potty training?  Yes  No If yes, describe his/her routine: \_\_\_\_\_

16. What does your child call his/her: Bowel movements: \_\_\_\_\_ Urination: \_\_\_\_\_

17. Does your child hit, kick or bite?  Yes  No

18. Additional Comments: \_\_\_\_\_