

Child's Name _____ DOB _____ Age _____

Infant Questionnaire

Baby's Sleeping Habits

1. Does your baby sleep better on his / her L-side R-side back stomach
2. Does your baby sleep better in silence normal noise
3. Does your baby sleep with a pacifier blanket stuffed animal _____
4. How does your baby prefer being put to sleep? placed in bed rocked _____
5. Does your baby tend to snore? _____

Baby's Temperament

6. Is your baby hot natured cold-natured neither
7. Does your baby enjoyed being held or left alone? _____
8. Does your baby enjoy a swing bouncer mobile walker _____

Health / Developmental Issues:

1. Was your baby's delivery normal premature _____ wks. cesarean
2. Has your baby had any major health problems? _____

2. Does your baby have Reflux problems? _____

3. Is your baby
holding his/her head up? _____ Age _____
turning over ? _____ Age _____
crawling ? _____ Age _____
sitting up ? _____ Age _____
holding their own bottle? _____ Age _____
drinking from a cup? _____ Age _____
walking ? _____ Age _____

4. Does your child have any allergies? _____

4. List any specific instructions or helpful hints to better meet your baby's needs.

Infant Schedule

1. Does your baby wake on his/her own or do you wake them up?

2. Your baby eats breakfast at home center at _____ o'clock

3. Your baby normally wakes at _____ goes to sleep at _____

5. Baby's Schedule (please specify)

6:30 a.m. _____

7:00a.m. _____

8:00a.m. _____

9:00a.m. _____

10:00a.m. _____

11:00a.m. _____

12:00a.m. _____

1:00 p.m. _____

2:00 p.m. _____

3:00 p.m. _____

4:00 p.m. _____

5:00 p.m. _____

6:00 p.m. _____

PRINT:

Person Completing Form _____

Relationship _____ Date _____