INFANT/TODDLER HEALTH AND DEVELOPMENT QUESTIONNAIRE

Child's Full Name: ______________________________

Date of Birth: ____________________ Sex: ____________________

Please answer the questions on this form.
We feel this information will help us be more effective in caring for your child.

NOURISHMENT

Type of food your child eats: Strained ☐ Junior ☐ Table ☐

How has child been fed? Held in Lap ☐ High Chair ☐ Other ☐________

Does your child use a bottle? Yes ☐ No ☐ Handle cup & spoon? Yes ☐ No ☐

Current feeding schedule: ______________________________

____

____

Schedule has been in use for: Days ☐ Weeks ☐ Months ☐

Any special feeding problems? Yes ☐ No ☐ ____________________

SLEEPING HABITS

How does child wake? Active ☐ Sluggish ☐ Crying ☐ Happy ☐ Fussy ☐

How does child sleep? Heavy ☐ Light ☐ Restless ☐

What time does child get up in the a.m.? ____________ Go to bed in p.m.? ____________

What is your child's nap pattern? a.m. nap time ____________ p.m. nap time ____________

Do you have a bedtime routine with your child? Yes ☐ No ☐

Rocking ☐ Singing ☐ Stories ☐ Talking ☐ Other ☐

DIAPERING/TOILETING

Does your child use: Diapers ☐ Potty Seat ☐ Special Toilet Seat ☐ Regular Toilet Seat ☐

Do you use: Disposable Diapers ☐ Cloth Diapers ☐ Training Pants ☐

Are plastic pants used? Always ☐ Sometimes ☐ Never ☐

Do you use: Oil ☐ Powder ☐ Others ☐

Is baby's skin highly sensitive? Yes ☐ No ☐ Frequent diaper rash? Yes ☐ No ☐

Are bowel movements regular? Yes ☐ No ☐ How many per day? ____________ What time? ____________

Is diarrhea or constipation a problem? Yes ☐ No ☐ ____________________

Has toilet training been attempted? Yes ☐ No ☐

HEALTH

Is your child taking over-the-counter or prescribed medication regularly at home? Yes ☐ No ☐

If yes, what? ______________________________

Is your child taking vitamins regularly at home? Yes ☐ No ☐

If yes, what? ______________________________

List any know allergies to food or environment. ______________________________

____

What is the allergic reaction? ______________________________

How is this treated? ______________________________

____

Have you ever suspected your child of having seizures? Yes ☐ No ☐

What was the cause? ______________________________

How was this treated? ______________________________

How do you consider your child's physical development? Normal ☐ Advanced ☐ Lagging ☐

Comments: ______________________________

____

SOCIAL/EMOTIONAL

Check the words that best describe your child's temperament or personality.

Affectionate ☐ Serious ☐

Aggressive ☐ Fearful ☐

Assertive ☐ Stubborn ☐

Cautious ☐ Friendly ☐

Curious ☐ Quiet ☐

Sensitive ☐ Rebellious ☐

Determined ☐ Sense of Humor ☐

Does your child use: a pacifier ☐ suck thumb ☐ security object ☐

When does your child use them?

Does your child have a "fussy" time? Yes ☐ No ☐ When? ______________________________

How is this handled? ______________________________

Does your child use special or unusual words/names for objects, places or people?

____

Is there anything else, medical or otherwise, that we need to know about your child?

____

______________________________ ______________________________

Signature of Custodial Parent/Legal Guardian **Date**