Infant/Toddler Development History-Supplement

Child's Name: _____ Birth Date: _____

Personal History

Type of Birth: _____ Complications: _____

Age child began to sit: _____ Crawl: _____ Walk: _____

Talk: _____ Does your child use special words for needs? _____

Home Language: _____ Does your child have a history of colic? _____

Does your child pull-up: _____ Crawl around: _____ Walk w/help: _____

Use a pacifier: _____ Suck thumb: _____

Does your child have a fussy time: _____ When: _____

How do you handle this? _____

Does your family have religious restrictions (i.e. doesn't celebrate certain holidays)? _____

Also, how can our program support your family's beliefs? _____

Does your child have cultural restrictions of any type of food? _____ If yes,

please list food: _____

Eating Habits

Does your child have a special diet or any feeding issues? _____

Describe, in detail, any preparation if your child is on special infant formula: _____

_____

_____

Is your child fed in: lap_____ high chair_____ other_____

Does your child eat with a: spoon_____ fork_____ hands_____ other_____

Toilet/Diapering Habits

Does your child get diaper rash frequently? _____ If yes, explain what to do when this happens: _____

After your child is cleaned from a soiled diaper do you use: oil_____ Vaseline _____ powder_____ lotions_____ other_____

Does your child have a problem with: diarrhea_____ constipation_____ other_____?

Bowel movements: regular_____ Number per day_____ Usual times_____

Have you attempted toilet training? _____ How would you like us to handle toilet training with your child? _____

Does your child have accidents: _____ What causes them: _____

Is your child frightened of the bathroom? _____ or of using the toilet? _____

Sleeping Habits

Does your child sleep in a: crib_____ bed_____ bassinette_____ other: _____

Does your child take a nap: ____ A.M time (to/from): _____ P.M time (to/from): _____

What does your child take to bed: _____

When waking up, what is your child's mood? _____

What time does your child go to bed at night? _____

What time does your child wake up in the morning? _____

Social Relationships

Has your child had experience playing with other children? _____

What can we do to help your child socialize? _____

Please describe, by approximate times, your child's current daily activities (i.e. awakening, eating time out of crib, napping, toilet habits, fussy time, night, bedtime, etc.)

AM SCHEDULE: _____ PM SCHEDULE: _____

_____ _____

_____ _____

_____ _____

_____ _____

Please indicate anything else you would like us to know about your child. _____

_____

_____

_____

Parent Signature: _____ Date: _____