



## **SLEEPING HISTORY**

1. Do you have any special ways of helping your child go to sleep?  Yes  No
2. Does your child cry when going to sleep? (infants only)  Yes  No
3. What is your child's present sleeping schedule?  
**Night time:** From \_\_\_\_\_ To \_\_\_\_\_ **A.M.:** From \_\_\_\_\_ To \_\_\_\_\_ **P.M.:** From \_\_\_\_\_ To \_\_\_\_\_
4. Does your baby (infants only) prefer to sleep on his/her:  stomach  side  back
5. Does your baby need a pacifier? (infants only)  Yes  No
6. Does your baby need a blanket?  Yes  No
7. Does your child need a toy?  Yes  No

## **FEEDING HISTORY**

1. Is your baby breast-fed? (infants only)  Yes  No
2. Is your baby bottle-fed? (infants only)  Yes  No
3. Type of bottle? (infants only) \_\_\_\_\_
4. Type of formula? (infants only) \_\_\_\_\_
5. How many ounces taken between burps? (infants only) \_\_\_\_\_
6. What is your child's present eating schedule? (specify amount and time for milk/formula, juice, food)  
Breakfast: \_\_\_\_\_  
A.M. Supplements: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
P.M. Supplements: \_\_\_\_\_
7. Has your child had any feeding problems?  Yes  No  
Describe: \_\_\_\_\_

## **TOILETING HISTORY**

1. How frequently does your child have a bowel movement? \_\_\_\_\_
2. Appearance of bowel movement? \_\_\_\_\_
3. Is your child toilet trained?  Yes  No
4. What word does your child use for urination? \_\_\_\_\_ bowel movement? \_\_\_\_\_
5. Does he/she use a potty-chair?  Yes  No
6. Does your child frequently have diaper rash?  Yes  No
7. How would you like us to treat your child's diaper rash? \_\_\_\_\_

**PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_