

# About Your Infant

Child's Name/Nickname: \_\_\_\_\_ Today's Date: \_\_\_\_\_

What FORMULA (or breastmilk) is your child eating? \_\_\_\_\_

If your child is on breastmilk, when do you plan to introduce FORMULA?

Partially: \_\_\_\_\_ then completely: \_\_\_\_\_

How is baby after eating (check all that applies)?  Gassy  Spits-up Some or  Often  Happy  Sleepy

How many oz. does baby eat at a time? \_\_\_\_\_ How many hours in between? \_\_\_\_\_ Total oz. ea day: \_\_\_\_\_

When do you plan to introduce cereal? \_\_\_\_\_ (Dr. sugg. 4 mos) Jar food? \_\_\_\_\_ (Dr. sugg. 5 mos)

Other eating plans/concerns? \_\_\_\_\_

What is the total # of hours baby sleeps out of 24 hours: \_\_\_\_\_ Hrs. Longest At Night: \_\_\_\_\_ Hrs.

How long, on average, is baby usually awake at a time? \_\_\_\_\_ Hrs. Longest so far? \_\_\_\_\_ Hrs.

How does baby fall asleep during the DAY? \_\_\_\_\_

At NIGHT? \_\_\_\_\_

Does baby use a pacifier? \_\_\_\_\_ If so, when do you plan on eliminating (we sugg. 1 yr)? \_\_\_\_\_

Any other forms of comfort for baby, When UPSET: \_\_\_\_\_

When TIRED: \_\_\_\_\_

When GASSY: \_\_\_\_\_

Favorite toy or blanket? \_\_\_\_\_

Special FAMILY situations? (*such as custody specifications, problems arising from situations, etc.*)  
\_\_\_\_\_

Siblings at home full time? (names & ages) \_\_\_\_\_

Step-Siblings/Parents and living arrangements: \_\_\_\_\_

Previous childcare child has attended: \_\_\_\_\_

Any problems with previous child care? \_\_\_\_\_

EXPECTATIONS of M & M Daycare \_\_\_\_\_  
\_\_\_\_\_

Do you have any questions or concerns that you'd like us to help you with in relating to baby? \_\_\_\_\_  
\_\_\_\_\_

What BABY BOOKS are you reading? \_\_\_\_\_

Other COMMENTS? \_\_\_\_\_  
\_\_\_\_\_

# Health History

Child's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Statistics at Birth: Wt: \_\_\_\_\_ Length: \_\_\_\_\_ Born Early Late? Weeks before/after due: \_\_\_\_\_

Any complications at birth (explain)? \_\_\_\_\_

Illnesses: *(please check)*

Does your child have any problems with any of these?  
diseases?

- Asthma
- Constipation
- Convulsions
- Diabetes
- Diarrhea
- Fainting Spells
- Frequent Colds
- Frequent Ear Infections
- Frequent Sore Throats
- Heart Trouble
- Skin Rash
- Soiling
- Stomach Upsets
- Urinary Problem

Has your child had any of these

- Bronchitis
- Chicken Pox
- Hepatitis
- Lice
- Measles
- Mumps
- German Measles
- Polio
- Ringworm
- Scarlet Fever
- Tuberculosis
- Whooping Cough
- Worms
- Impetigo

Other ILLNESSES? *(besides above)* \_\_\_\_\_

Has your child been HOSPITALIZED? *(explain)* \_\_\_\_\_

Has your child had INJURIES with fractures or loss of consciousness? *(explain)* \_\_\_\_\_

Any other members of your family with SERIOUS ILLNESS recently? \_\_\_\_\_

Any other members of your family with history of: ASTHMA DIABETES EPILEPSY

Pediatritian: \_\_\_\_\_ Address: \_\_\_\_\_

## Referral Sources (Please check one or more)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Drive-by Sign              | <input type="checkbox"/> Flyer                        | <input type="checkbox"/> Newspaper                      |
| <input type="checkbox"/> 4 C's Referral (Wayne Co.) | <input type="checkbox"/> CCN Referral (Washtenaw Co.) | <input type="checkbox"/> Belleville Chamber of Commerce |
| <input type="checkbox"/> Belleville Schools         | <input type="checkbox"/> Parental Referral            | <input type="checkbox"/> Daycare Referral               |
| <input type="checkbox"/> Other _____                | & Name Parent _____                                   | & Name Daycare: _____                                   |