little beginnings
LEARNING CENTER

infant intake

Name _____ Date _____
Address _____ Telephone _____
Parent _____ Birth Date _____

Heath: (check all that apply)

❑ Allergies _____ ❑ Colds _____ ❑ Colic _____ ❑ Convulsions _____
❑ Ear Infections _____ ❑ Other (describe) _____

Eating Schedule- Time: Food Type:

_____ _____
_____ _____
_____ _____
_____ _____

Type of Food:

Formula _____ Milk _____
Strained _____ Junior _____
Table Food (specify) _____
What types of snacks _____

Child is Fed:

❑ On lap ❑ Highchair ❑ Infant Seat ❑ Other _____
Special feeding problems _____
Food Allergies _____ Favorite Foods _____
Foods Refused _____

Amount of food at:

Breakfast _____ Lunch _____
Snack _____ Amount of Milk _____

Sleep Habits:

Falls asleep easily _____ Sleep aids _____
❑ Tummy sleeper ❑ Back sleeper ❑ Side sleeper

How Long:

Morning nap _____ Afternoon nap _____

Comfort:

Fussy time (when and how long) _____
Methods of comfort _____
❑ Holds bottle ❑ Pacifier ❑ Sucks thumb

Child likes to be:

❑ Held ❑ Rocked ❑ Sung to ❑ Stories ❑ Other _____

Diapering:

Lotion or cream _____ Type of disposable diapers _____