Infant/Child History

Child's Name_____ DOB_____ Date_____

Health

1. Has your child had any serious illness or been hospitalized?_____ If yes, please describe:

2. Does your child have any chronic health conditions? (eg. asthma, ear infections, tubes, rashes, etc)

3. Does your child have any allergies? (including hay fever, insect bites, medication, food, etc)

4. Does your child take any medication regularly?

5. Does your child have any specific fears? (eg. Animals, noise, dark, etc

6. Does your child have any physical or emotional disabilities or conditions that you are concerned about?

Eating

1. What does your child eat and/or drink?

2. Favorite foods:

3. Foods refused:

4. What is your child's feeding schedule/routine? (include amounts as well as approximate times of day)

Sleeping

1. Where does your child sleep at home?

2. Sleep schedule:

3. How does your child like to go to sleep?

4. In what position does your child sleep?

Elimination

1. Does your child have a diaper rash: often?____ sometimes?____ never?____ What is used to treat this condition?

2. Are your child's bowel movements regular? _____
   Number of times per day (approximate)_____

Personal/Social

1. What are some of your child's favorite activities?

2. Favorite toys?

3. How does your child like to be comforted?

Parent/Guardian

1. What is your philosophy on child rearing?

2. How do you handle discipline?

3. What would you like your child to gain from Bambini?

4. Other comments: