



Help Us Get to Know Your Little One!

Name: _____ Birthday: _____

Sleeping Habits & Temperament

I am: happy fussy colicky

I enjoy being held: yes no

I enjoy: the swing a bouncy chair floor time

I sleep well on my back*: yes no

To sleep I prefer: placed in crib rocked other _____

Health

Major health problems?

Reflux problems? How do you handle it?

Allergies?

Medications*?

Milestones

Holding head up at ___ months

Turning over at ___ months

Sitting up at ___ months

Crawling at ___ months

Holding bottle at ___ months

Drinking from cup at ___ months

Walking at ___ months

I started eating

food/table food at ___ months



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Daily Schedule

I have a bottle every _____ hours

I eat breakfast @: home center

I eat jar / table food: (please circle)

once twice three

I typically eat every _____ hours

I nap every _____ hours

Helpful Hints

Please list any specific hints or instructions to help us get to know your child better



*Per state licensing a doctor's note is required for infants to sleep anywhere other than in a crib on his/her back. This includes car seats, swings, and bouncy chairs without written instructions from a doctor.

*Per state licensing no items may be placed into cribs with infants including but not limited to stuffed animals, blankets, or bumpers.