

TELL US ABOUT YOUR CHILD

CHILD'S NAME _____	NICKNAME _____	DATE OF BIRTH _____ / _____ / _____
EMERGENCY NUMBERS (1) _____ (2) _____		
SPECIAL MEDICAL CONDITION(S) _____		

Eating Habits (what, when, how much, favorites, dislikes) _____

Allergies to foods: _____

Allergies / Other _____

Sleeping (when, how long, soothing hints, rituals) _____

Bathroom/Diapering (what works, what's normal) _____

Activities (favorites, dislikes, familiar songs) _____

What is separation like for your child? (Is this the first time or any hints?) _____

Interaction with other children their age and how did they do _____

Developmental Progress: _____

Special Family Celebrations _____

Does your child have any particular habits or mannerisms such as thumb sucking or nail biting? If so please describe:

What is important to YOU in raising your child? _____

Do you have any outstanding concerns? _____
