All About My Child

Child's Name ___________________________

Eating

1. Is your child on formula, breastmilk, or whole milk?
   ____
2. When are your child's general feeding times?
   ____
3. How many ounces does he/she drink in one feeding?
   ____
4. Does your child use a bottle or sippy cup?
   ____
5. Does your child prefer bottles room temp, warmed, or cold?
   ____
6. Does your child hold their own bottle/cup?
   ____
7. Does your child eat baby cereal or table food?
   ____
8. What are your child's favorite snacks/foods?
   ____
9. Does your child have any food allergies?
   ____
10. Other: ____
    ____

Sleeping

Infant

1. How many times a day does your child nap?
   ____
2. What times does your child usually nap?
   ____
3. How long does your child usually nap?
   ____
4. Does your child use a soother to fall asleep? (pacifier, sound machine, etc.)
   ____
5. What are your child's sleepy cues?
   ____
6. Other: ___________________________________
   ____