Bright Path
The best start in life

Infant Developmental History

Today's Date _____Child's Full Name _____
Date of Birth _____ Nickname _____ Gender: M F

Health

1. Is your child taking any medications now? Yes No
(Including aspirin, laxatives, vitamins, etc.)

If yes, what? _____ Why? _____

3. What arrangements have you made for the care of your child should he/she become ill at the center?

_____

_____

4. Does your child have any special needs or disabilities? Yes No
If yes, please describe: _____

5. Has your child ever been hospitalized? Yes No
If yes, please describe: _____

6. Does your child chew on unusual things such as cribs, window ledges or hair? Yes No
If yes, please describe: _____

7. Has your child had any of the following? (Please Circle.)

Premature birth	Trouble breathing at birth
Birth injury/Defect	Head Injury
Convulsions/Seizures	Allergies (including eczema, hives, drug, food intolerance, hay fever, wheezing, asthma, insect stings)

If yes, please describe: _____

Development

At what age did your child begin to walk?_____

How do you comfort your child? _____

What are your child's favorite toys? _____

What are your child's favorite activities? _____

What is the primary language(s) spoken in your home? _____

Has your child previously been in a group childcare setting? _____

Sleeping

Please describe any specific ways in which you help your child to fall asleep:

_____

_____

What is your child's current sleeping schedule?

Morning Nap: Begin _____ End _____

Afternoon Nap: Begin _____ End _____

Nighttime: Begin _____ End _____

Does your child use a pacifier at naptime? Yes No

Does your child use a special toy at naptime? Yes No

Does your child use a blanket at naptime? Yes No

Feeding

Is your child breast-fed? Yes No Bottle fed? Yes No

Type of bottle: _____ Nipple Size: _____ Brand of Formula: _____

What is your child's present eating schedule? (Please specify approximate amounts.)

	Food	Milk/Formula
Breakfast	_____	_____
Morning Snack	_____	_____
Lunch	_____	_____
Afternoon Snack	_____	_____

Does you have any concerns regarding your child's eating habits? Yes No

If yes, what are they?

_____

_____

Toileting

How frequently does your child have a bowel movement? _____

Does your child frequently have diaper rash? Yes No

If so, how is it treated? _____

Additional Information

_____

_____

_____

_____