Welcome Questionnaire for Babies!!!

Child's Name_____

Was your baby full term? YES_____ NO_____

If not, at how many weeks was your baby born? _____

Is there any medical information that would be helpful for us to know in the care of your child?

_____

***If your child needs any medication or has any known allergy's or has a family history of allergies, please inform the director.**

Is your baby rolling over? YES NO

Does your baby sleep through the night? YES NO

How many hours does the baby sleep at one time?_____

How many times does your baby wake up at night?_____

Where does your baby sleep at home? (Crib, bouncy seat, parents bed)_____

Is there anything special we should know about the way your baby sleeps or goes to sleep?

_____

How often does your baby nap?_____ When?_____ How long?_____

Does your baby suffer from colic? YES NO

How do you treat it?_____

How do you sooth your baby? _____

How does your baby self sooth? _____

Does your baby use a pacifier? YES NO What type?_____ When?_____

Do you Breast Feed? YES NO

Will we be storing breast milk? YES NO

What Formula do you use?_____

How often does your baby take a bottle?_____ What time during the day? _____

How many ounces at each feeding? _____

How does your baby like their bottle? cold cool room temperature warm very warm

Does your baby drink from a sippy cup? YES NO

Will we be feeding your baby solids? YES NO How often? Breakfast Lunch

Does your baby eat table food? YES NO If yes, what? _____