Infant/Child History

Child's Name_____ DOB_____ Date_____

Health

1. Has your child had any serious illness or been hospitalized? Yes ☐ No ☐
   If yes, please describe:

2. Does your child have any chronic health conditions? (e.g., asthma, ear infections, tubes, rashes, etc.) Yes ☐ No ☐
   If yes, please describe:

3. Does your child have any allergies? (including hay fever, insect bites, medication, food, etc.) Yes ☐ No ☐
   If yes, please describe:

4. Does your child take any medication regularly? Yes ☐ No ☐
   If yes, please describe:

5. Does your child have any specific fears? (e.g., Animals, noise, dark, etc.)
   Yes ☐ No ☐
   If yes, please describe:

6. Does your child have any physical or emotional disabilities or conditions that concern you? Yes ☐ No ☐
   If yes, please describe:

Eating

1. What does your child eat and/or drink?

2. Favorite foods:

3. Foods refused:

4. What is your child's feeding schedule/routine? (include amounts as well as approximate times of day).

Sleeping

1. Where does your child sleep at home?

2. Sleep schedule:

3. How does your child like to go to sleep?

4. In what position does your child sleep?

Elimination

1. Does your child have a diaper rash: ☐ Often? ☐ Sometimes? ☐ Never?
   What is used to treat this condition?

2. Are your child's bowel movements regular? Yes ☐ No ☐
   Number of times per day (approximate):

Personal/Social

1. What are some of your child's favorite activities?

2. Favorite toy?

3. How does your child like to be comforted?

Parent/Guardian

1. What is your philosophy on child-rearing?

2. How do you handle discipline?

3. What would you like your child to gain from Bambini?

4. Other comments: