Histories

FEEDING

Breast-fed? Yes / No How long?__________ On demand? Yes / No

Formula used? Yes / No If yes, when introduced?___________________________

Type of formula used:____

Introduced to solid foods? Yes / No If yes, what & when?______________________________

When was cow's milk introduced?___________________ Current diet (picky eater?) Yes / No

General

SLEEPING HABITS Describe the following:

At present:____

Napping habits:____

Trouble staying awake/falling asleep:____

BEHAVIOR & EMOTIONAL HISTORY

At school: Performance / Anxiety / Separation Anxiety

Other:____

At home: Describe relationship with friends, family siblings:________________________

____

Potty training:____

Interests/activities:____

Circle any of the following that your child has: Nail biting / Thumbsucking / Nightmares /

Bad temper / Fears / Irritability / Wets bed / Speech problems / Jealousy /

Can't toilet train / Breath holding / Self abuse habits

MILESTONE AGES

Sitting________ Talking________Walking________Rolling over________Dressed self________

Any additional information?

Thank you for your time! **Signature**____