

Has your child been introduced to solids? Yes No If Yes, what type? Baby food Table food

What is your child's feeding schedule? Please complete chart. (Only list foods to which your child has successfully been introduced)

Solids	Type	Consistency	Amount	Times
Cereals				
Cereals				
Cereals				
Vegetables				
Vegetables				
Vegetables				
Vegetables				
Fruits				
Fruits				
Fruits				
Fruits				
Meats				
Meats				
Snacks				
Snacks				

Does your child have any food sensitivities? Yes No If Yes, please Identify: _____

Describe your child's appetite: _____

What foods does your child like and dislike? _____

Sleep

Describe your child's sleep routine (include times and lengths of naps) _____

Describe ways you help your child go to sleep (include position, special blanket, lighting, sound, etc.)

Does your child usually cry when going to sleep? Yes No If Yes, for how long? _____

Does your child usually cry when waking? Yes No

Where does your child usually sleep? Please describe: _____

