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Baby / Infant Information Sheet

Baby's Name:_____Birth Date:_____

Feeding:
Is your child breast fed?_____Bottle fed?_____Does he/she use a cup?_____

Does your baby have a good appetite?_____

Has your baby had any feeding problems?_____

What are your baby's favorite foods?_____

What foods does your baby dislike?_____

Does your baby have any food allergies?_____

Please describe a **typical daily menu** for your baby:
Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Sleeping:
What is your baby's typical sleeping pattern during the day?

A.M._____

P.M._____

How long does your baby sleep at night?_____

How do you help your baby go to sleep?_____

Does your child have a special "attachment toy" to sleep with? (for example, blanket, teddy bear, pacifier, etc.)_____

_____