God's Bright Treasures Ministry

Parent Questionnaire for Infants (6 weeks-12 months)

Dear Parents,

Please fill out this questionnaire to help us provide your child with a smooth transition and a successful child care experience. Thank you!

CHILD'S NAME_____

DATE OF BIRTH _____

Physical Development (√ items that your child is able to do)

____Hold head up while on tummy _____ Roll from tummy to back

____Push body up with arms while on tummy _____ Sit with support

____ Sit unassisted _____ Roll from back to tummy

____Gets into crawling position ____Crawl forward/backward

____Walk while holding onto furniture _____Stand

_____ Walk with assistance _____Walk unassisted

Sleeping Habits

My child usually naps _____ times a day from: _____ to _____

_____ from: _____ to _____

_____ from: _____to _____

My child sleeps at night from _____p.m. to _____a.m.

Please explain your nap/bedtime routine.

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Does your child sleep with any special object?

Does your child sleep in his/her crib at night? _____ Yes _____ No*
*If No, please explain:

Eating Habits
Does your infant consume breast milk? YES or NO
Does your infant both breast feed and bottle feed? YES or NO
If yes, when do you use bottle vs. breast?
_____

Does your infant consume formula? YES or NO Type? _____

How many ~~oz~~ounces?_____

Temperature of bottle to be given _____Room temperature ____Cold _____Warmed

Anything we need to know that may help us when giving your child their bottle? (Slow eater, burp often, etc)
_____
_____
_____

Does your child drink from a cup during meals? YES or NO __What do they drink? _____

Which foods (baby or table) have you tried with your child?
_____
_____
_____
_____
_____
_____
_____
_____
_____

List amount of food, types of food, and times your child usually eats below:

Breakfast: _____

Lunch: _____

Snacks: _____

Does your child use a pacifier? YES or NO If yes, when? _____

Play & Social Interaction:

Do you use sign language with your child?

Your child's favorite toys and activities:

Special Medical Considerations
Please list any:

Does your child have any distinguishing birthmarks?

What are your goals and expectations for your child at God's Bright Treasures Ministry?

Signature of Parent or Legal Guardian Date

Updated_____	Updated_____	Updated_____	Updated_____
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