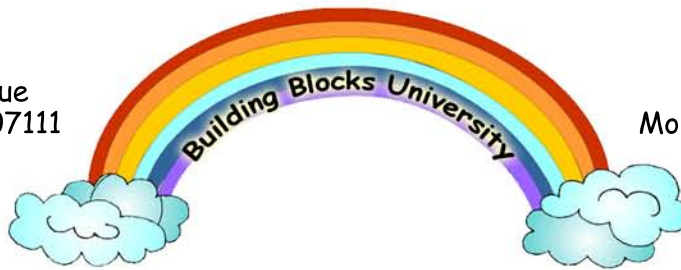


Irvington Facility
1211 Springfield Avenue
Irvington, New Jersey 07111



Montclair Facility
85A Walnut Street
Montclair, New Jersey 07042

PERSONAL INFORMATION RECORD FOR INFANT/TODDLER

Child's name _____ Age _____

1. What is your child's current daily sleeping schedule?
Morning wake-up time _____ Evening bedtime _____
Daily naps _____
2. Is your child sleeping through the night? _____
If not, when does child usually wake up at night?
3. What upsets or frightens your child?
4. What does your child find soothing or comfortable?
5. How is your child now reacting to strangers?
6. Is your child using a cup, a bottle or both? _____
Are you breast feeding your child? _____ If yes, at what times?
7. What are the times your child is now receiving the bottle each day?
8. Give the number of ounces your child is now taking at each bottle feeding.
9. Is your child taking formula, whole milk, skim milk or other?
10. Give any special instructions for preparing formula, if any.
11. Are there any other special instructions concerning bottle feeding your child?
12. Is your child now on baby food or table food?

13. List foods your child is now eating.

Vegetables

Fruits

Meats

Juices

Breads

14. Is your child now eating finger foods?
If yes, please list.

15. List any other foods your child is now eating.

16. Where does your child spend his/her waking hours?
(Crib, playpen, crawling on floor, etc.)

17. What toys and activities make him/her happy?

18. When does your child usually have bowel movements?

19. Has your child begun potty training? _____ If yes, describe his/her routine.

20. What does your child call his/her
Bowel movement _____ Urination _____

21. This space for any other information you wish to share about your child.

Parent's signature _____ Date _____