

TODDLER PROFILE

Child's Name: _____ Birth Date: _____
Parent's Name: _____ Today's Date: _____

FEEDINGS:

1. Does your child receive a bottle? _____ If yes, when?

2. Does your child feed him/herself? _____ Does he or she use a spoon?

3. Does your child have any food allergies?

4. Does your child have any feeding problems?

SLEEPING:

1. Do you have special ways to help your child go to sleep?

2. How long does your child usually sleep during naptime?

3. Does your child need anything special to sleep with?

TOILETING:

1. Is your child toilet trained? _____ If no, when do you plan to start? _____
_____ If yes, does he/she use a potty chair? _____
2. What word does your child use for: Urination? _____ Bowel Movement?

3. Does your child have frequent diaper rash? _____ What do you use to cure diaper
rash? _____

DEVELOPMENTAL HISTORY:

1. How do you comfort your child?

 2. Does your child seem well most of the time?

 3. In a year, has your child had as many 3 ear infections?

 4. Does your child have ear tubes? _____ Since when?

 5. Are you concerned about your child's vision or hearing?

- At this time, what are your goals and or desires for your child while at Appletime? _____

