CAPS Care Intake Form

For Children Under 2 Years

Child Name(first, middle, last):_____ Birth Date:_____

Parent Name(first, middle, last):_____ Phone Number:_____

Address:_____

HEALTH: **Child has frequent colds, ear infections, colic, etc. – If yes, please describe**
MEALS: **Current Feeding Schedule:**
Length of Time on Current Schedule:
Food Type: **____ Breast Milk ____Formula ____Strained ____Junior ____Table ____Other-please describe**
When eating, child is: ____Held in lap ____In highchair ____Other-please describe
Feeds Self: ____Yes ____No
Special Feeding Problems: ____Yes____No **If yes, please describe:**
Food Allergies: ____Yes ____No **If yes, please describe:**
Favorite Foods:
Refused Foods:
Updates:

SLEEP:
Current Sleep Schedule:

Length of Time on Current Schedule:

Falls Asleep Easily: ____Yes ____No

Mood Upon Waking – Describe

Takes Favorite Toys to Bed – Children over age 1: ____Yes ____No
If yes, list toys

Sleep Position – Child under age 1
Please note: Children under 1 year will be placed to sleep on their backs, unless a written statement from physician is attached

____Back ____Side or stomach (physician statement attached)

Sleep Position – child age 1 year or older

____Back ____Side or Stomach

Updates:

DIAPERING/TOILETING
Diaper Type: ___Cloth ____Disposable

Plastic Pants Used: ____Always ____Sometimes _____Never

Highly Sensitive Skin: ____Yes ____No

Frequent Diaper Rash: ____Yes ____No

Lotions, powders, salves used: ____Yes ____No If yes, list product name(s):

Toilet Training Attempted: ____Yes ____No
If yes, describe routine:

Type of toilet seat used at home: ____Potty chair _____Special Toilet Seat ____Regular toilet seat

Regular bowel movements: ____Yes ____No
How often: Time of day:

Toileting Problems: ____Yes ____No

If yes, please describe:

Updates:

VERBAL COMMUNICATION
Family's spoken language

____English _____Spanish ____Other – If "other", please specify

Age child began talking: **Child speaks: ____Words _____Sentences**

Words used to describe special needs:

Updates:

COMFORTING
Does your child have a "fussy" time?

____Yes ____No If yes, please specify time

How is "fussy" time handled?

Child likes to be:

____Held ____Sung to ____Rocked ____Read to ____Other – please specify

Special things you say or do to comfort child:

Updates:

SELF EXPRESSION
What causes your child to be angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional Comments

Updates

PHYSICAL AND SOCIAL DEVELOPMENT
Is your child able to – check all that apply

____Sit up alone ____Pull up ____Crawl _____Walk holding on ____Walk without support

Is your child used to playmates? ____Yes ____No

Comments

Updates

MISCELLANEOUS	
Child's favorite indoor toys and activities – Specify	
Child's favorite outdoor toys and activities – Specify	
Updates	
Parent Signature:	**Date:**