

Infant Functional Form

Child's Name _____

Date _____

Please check all those that apply to your child.

- ____ 1. Has your child been more irritable/less consolable?
- ____ 2. Has your child had difficulty sleeping?
- ____ 3. Has your child's sleeping pattern changed? Please explain: _____
- ____ 4. Has your child's digestion pattern changed? (i.e. constipation/diarrhea)
- ____ 5. Has your child intake of food been less or more (circle which one)?
- ____ 6. Has your child needed more parental attention/affection?
- ____ 7. Has your child been more distant/less affectionate?
- ____ 8. Has your child had trouble with nursing or taking a bottle?
- ____ 9. Has your child had a developmental milestone and then lost it? (i.e. able to roll over but now can no longer do so)? Please explain: _____
- ____ 10. Has your child shown unwarranted emotions such as fear? Please explain: _____

- ____ 11. Has your child shown a new physical issue (i.e. sucking thumb or blanket) for comfort? Please explain: _____

- ____ 12. Has a normal daily activity shown change (i.e. cries now when put in car seat)? If yes, please explain: _____

- ____ 13. Have any normal play patterns changed? Please explain: _____

- ____ 14. Have you noticed any changes in relationships with grandparents/daycare providers? Please explain: _____
